DELAWARE HEALTH CARE COMMISSION

Final Report
to:

Department of Health & Human Services
Health Resources and Services Administration
CFDA # 93.000
State Planning Grant Program

October 29, 2001

Executive Summary

The Delaware Health Care Commission (DHCC) places critical priority on completing activities that assist in expanding access to appropriate healthcare to uninsured Delawareans. Through the receipt of two federal grant awards through the Health Resources and Services Administration (HRSA), the Commission is overseeing a process referred to as the "Uninsured Action Plan" (UAP). The UAP has two components: planning and policy direction, and implementation of direct service delivery initiatives. The State Planning Grant program provided the financial means by which to complete the thorough and comprehensive research needed for planning and policy direction.

As a result of our State Planning process and the simultaneous experience gained as a grantee through the Community Access Program which is integrating providers of services to the uninsured, the Commission recognizes two clear objectives required to meet the above stated goal; 1) supporting and building the safety net, and 2) identifying pathways and partnerships for making affordable health insurance coverage more widely available to employers and individuals.

Nearly three quarters of Delaware's uninsured work and have incomes over the federal poverty line, but are uninsured either because insurance isn't offered as a benefit of employment or it is too expensive to be affordable. A healthy and robust economy needs a properly trained and healthy workforce. Lack of access to appropriate care prevents the uninsured from maintaining good health. Good health is an essential ingredient to economic growth in Delaware.

Uninsured Individuals and Families

The most recent survey research completed in Delaware states that approximately 86,500 Delawareans are uninsured. The principle source of this information is the 2001 Current Population Survey (CPS) in which an effort was made to improve the quality of the insurance status measurement. Uninsured individuals represent approximately 12.7% of the total Delaware population- a percentage that has gone down from 14% in the 2000 CPS.

Sixty nine percent of Delaware's uninsured are working, and eighty percent are above the poverty line. There are many other demographic variables detailed in the report and its appendix. Our path forward focuses on targeting low-income individuals, as compared to the percentage of the uninsured that earn above Delaware's median income ($43,000.00).

Employer-Based Coverage

Both quantitative and qualitative research was conducted on statewide small businesses (less than 50 employees). This research clearly indicates that cost, or the perception of cost, is the single determinant of a business's decision to offer or not offer health insurance benefits. This is despite the majority of these employers stating that they do feel a significant obligation to do so, and recognizing that lack of this benefit dramatically impacts their ability to recruit and retain good employees.

The most striking lesson learned through the research and consensus building process is the high level of misunderstanding and confusion that exists in small businesses about the topic of health insurance. Employers who do not offer coverage, over sixty percent of the time, believed actual

costs of insuring an employee to be nearly double that of actual costs. Many employers indicated confusion and difficulty in gathering information, making informed purchasing decisions, or tax treatment of the cost of providing health insurance benefits.

Health Care Marketplace

Delaware's economy has changed drastically during the course of our planning process. We have a limited amount of major insurers, and a recent announcement of one such company's plan to leave our market. This results in limited competition and prohibits smaller insurers from lowering their premiums. Recent national events have affected the stock market and made it difficult for insurers to recoup any underwriting losses. In addition, workmen's compensation premiums (mandatory coverage) are going up and creating even more hardship on employers operating budgets. These increased expenses in combination with the declining economy and lessened consumer spending are not helping employer bottom lines nor creating an environment conducive to dialogue about incurring additional expense; e.g. health insurance coverage for employees.

Delaware has however made significant strides in recent years to expand public programs. The Diamond State Health Plan (the State's Medicaid managed care program) provides coverage for adults up to 100%FPL and pregnant women and infants to one year up to 200%FPL. The Delaware Healthy Children Program (the State's S-CHIP) provides coverage to children in families up to 200%FPL. Delaware's Community Healthcare Access Program provides free or discounted primary care and specialty services to adults between 100-200%FPL and undocumented citizens up to 200%FPL.

Options for Expanding Coverage

The Delaware path forward consists of several types of strategies; education, strengthening the safety net, forging public/private partnerships, and building on existing resources. Inherent to each of these activities is continued outreach to individuals who may currently be eligible for participation in public programs.

Employer Education- Develop and support a means of providing easily understandable information about how to purchase health insurance, particularly for small businesses.

Strengthening the Safety Net- The Delaware Community Healthcare Access Program (CHAP) links our safety net providers in an enrollment based system in which eligible patients are assigned to a volunteer or low cost medical home. CHAP also provides access to a statewide network of volunteer or discounted medical subspecialty services, and dialogue is underway for the statewide availability of discounted diagnostic (laboratory and radiology) services. CHAP eligibility requires completion of a universal financial and health status screening process, income between 100-200FPL, and ineligibility for a public insurance program. There are approximated to be between 11,000-14,000 uninsured individuals in this bracket of eligibility. As part of the state planning process, the need for a comprehensive assessment of safety net capacity and financial viability was identified. A Request for Proposal process has been initiated. It is expected that information gleaned through this process will provide direction as to the best means of supporting the provision of service by the safety net to individuals for whom the concept of insurance has little meaning. Ideas that have been broadly explored but warrant more in-depth analysis include development of limited benefit coverage programs for individuals enrolled in the CHAP, providing

direct subsidy to the CHAP network of safety net providers, or exploring community based systems development initiatives.

Target the Working Uninsured through Public Private Partnerships- Devise a plan that leverages state and federal dollars, and/or blends those dollars with private sector dollars to produce low cost products tailored to small employers who typically employ low wage workers. These are not mutually exclusive strategies but rather possibilities that must be closely coordinated for incremental and evolutionary implementation.

- Expand the Delaware Healthy Children Program (DE SCHIP) to cover parents of enrolled children and eligible but unenrolled children.

- Implement a "one third share" plan in which a less comprehensive benefit package is made available to employees through their employers. Premium costs are shared between employer, employee, and "one-third" state subsidy. A typical one third share is $50- a cost which employers indicated is within their range of willingness to pay.

- Further explore the feasibility of using cooperative purchasing strategies. Though national experience demonstrates that purchasing pools have not been very successful in lowering cost, they have delivered primary benefits of greater choice and administrative simplicities. Delaware individuals and businesses continue to have much interest in purchasing pools and a conceptual belief that they offer savings. Pooling strategies warrant further study with results that address actual impact on cost either included as a dispelling component of our employer education strategy, or further acted upon.

- Further explore employer premium assistance programs given the recent passage of the Health Insurance Flexibility and Accountability Demonstration (HIFA).

Consensus Building Strategies

Key stakeholders and members of the public were involved throughout our planning process through the use of a consensus-building model adapted from a model termed the "Assembly Method". Use of this method requires that key stakeholders be pulled together at the onset of the process in order for issues to be framed. A core group then oversees the completion of research and information gathering activities, and reconvenes the larger group of stakeholders at such time that findings can be shared and input received. As the final leg in the process, the core group formulates a strategy based on input received from stakeholders to review and applicably modify. Delaware utilized this series of three policy conferences, beginning in February 2001, meeting again in June 2001, but due to September's national events, our third policy conference has had to be postponed.

Fortunately, our state planning period has been administratively extended for an additional year during which time we can convene our stakeholders for final digestion of our strategy. As well, we intend to continue gathering input from key constituencies (e.g. legislators and State Administration) and complete additional research that will further exemplify the feasibility of our path forward.

Recommendations to States

A significant allocation of time and the commitment of key individuals to the planning process are required at the onset. One year sounds like a lot of time but in actuality was not enough. To clarify this point, the workgroup overseeing our state planning process was comprised of leaders from the health industry, state government, and universities. The workgroup met biweekly for the year and sometimes more often. Meetings averaged three hours in length and represented an extraordinary commitment on the part of all.

In terms of the effectiveness of varying types of research conducted, we encourage other states to think carefully as to the target participants, locations, times of day, and recruitment strategy for focus groups. We found the recruitment process to be inordinately difficult and the hardship experienced during that process in some ways diminished our enthusiasm for the results rendered.

Lastly, we strongly recommend careful consideration to the role played by the safety net as insurance expansion strategies are postulated. The safety net's capacity, financial viability, and ideological willingness to be a part of systemic state level change must be assessed and incorporated to the planning process. In addition to being significantly impacted by new patients and new health plans, the safety net will always treat patients for whom the term "insurance" has little to no meaning. This too is a critical concept to be regarded in planning activities.

Recommendations to the Federal Government

Multi-faceted, targeted strategies that build on a strong safety net as well as employer sponsored insurance coverage are required as the general solution towards expanding access to coverage to more uninsured Delawareans. However, in order for Delaware to move toward more universal health insurance coverage for the uninsured, financial resources from the federal government are prerequisite.

We are greatly appreciative of the flexibilities and technical assistance that has been federally provided through this process, and look to the recent passage of the HIFA as an excellent example of the additional federal flexibility required of states to make innovative public and private partnerships actually work.

Section 1. Uninsured Individuals and Families

Introduction

This research has drawn on a series of survey research data sets collected in Delaware to produce the findings that follow. There are three principal sources. First, there is the Census Bureau's March Current Population survey with a sample of between 600 and 700 households in Delaware analyzed between 1982 and 2000 when health insurance questions were asked. Second, the Behavioral Risk Factor Survey System has been conducted monthly since 1989 in Delaware with sample sizes increasing from approximately 1800 adults to 3500 adults today. The third source of information is the Consumer Assessment of Health Plans Survey or CAHPS, which in Delaware is a sample of 1800 adults that has addressed these issues since 1996.

All of these surveys address the issue of health insurance although in not precisely the same way or with precisely the same focus. However, together they are powerful sources that provide insight to different aspects of the problem and most importantly since they provide parallel measurements taken at the same time, they increase our confidence in the results.

This summary of findings is intended to point out the key characteristics of the uninsured in Delaware and following that to provide commentary on different aspects of the problem. More detailed information can be found in Appendix A.

Delaware's Uninsured.

In this section the demographic characteristics of the uninsured are presented from two different perspectives. The first perspective looks at the characteristic and how the probability of being uninsured varies with that characteristic. The second view examines only the uninsured to see how the characteristic might assist in designing programs or approaches toward mitigating the problem.

Delaware's population was 783,600 in 2000 according to the decennial census. Of those 759,017 are found within households. In addition there are 13,073 persons who live in non-institutional group quarters who could be eligible for the surveys. According to the most recent CPS data released on September 28, 2001 11.2% (3-year average) of Delawareans were uninsured during 2000. This would suggest that approximately 86,500 people were in that status.

Approximately 82.4% of all Delaware households have health insurance for everyone in the household. Another 5.3% of households have no health insurance for any of its members. The remaining 12.3% of households have some members with insurance and others without.

It should also be noted that an effort was made in the latest CPS survey to improve the quality of the measurement of insurance status. This change produced a rate significantly below that observed in prior years. Using the previous measurement, about 12.7% of Delawareans would have been estimated to be uninsured. The percentage uninsured in the US in 2000 was 14%. Thus, Delaware is in somewhat better condition on this indicator.

Income. The amount of income a person has can have a decided impact on the probability of having health insurance. First, if a household has a small enough income relative to their household size, individuals in that household may qualify for Medicaid. Second, children in households that fail to qualify for Medicaid may qualify for the SCHIP program. Third, individuals

with incomes above 200% of the poverty level are more likely to have insurance because they are working. In addition, if they are working at jobs where the cost of the benefit is not large relative to their salary, employers are more likely to provide health insurance and employees are more likely to take it. Finally, if the household income is high enough, health insurance can be purchased without undue strain on the household budget or they may even "self-insure".

Currently in Delaware, more than 20% of the persons in households with incomes less than $20,000 report being without health insurance. As household income rises to $50,000 (the median household income in Delaware is about $43,000) the percentage of uninsured falls to 8%. Similar numbers are found in the poverty data. For those persons living in households that are below the poverty level 27% are without health insurance. It should be noted that these individuals should qualify for Medicaid. As household income increases to 2.5 times the poverty level, the proportion of uninsured declines to 7.7%.

Among the 86,500 uninsured, 80% are above the poverty line and some 30% live in households with incomes exceeding $50,000. These data suggest that several things. First, there is an opportunity cover more people with Medicaid (17,300). Second, there may be some significant population that will not access the program for a variety of reasons. Third, there is a significant group that either does not know about the program or hasn't seen the need to access the health care system while they are without health insurance.

On the higher end, there is evidence to suggest that the self-employed are almost twice as likely to be without insurance compared to those working for employers. However, it would not be uncommon to find a married couple each working and making $25,000 ($12 per hour) who are either not offered coverage or do not take it because of the cost.

Roughly 75% of uninsured children (0-18) are living in households with incomes less than 200% of the poverty level and thus should qualify for Medicaid or SCHIP.

Median household income in Delaware is $47,438 which ranks 7th in the US and 13% above the US median household income. Delaware was one of six states that increased its median household income over 1999. Both of these facts are positive with respect to health insurance coverage now and in the future.

Age. While age may not be the deciding factor as to whether a person has health coverage, it is an influential characteristic. For those who are 65 years of age or older, Medicare simply takes care of the problem. In contrast, the health insurance statuses of those who are 0-17 years of age are dependent on the decisions and situation of their caretaker. Somewhat more than one child in ten (12.8%) in Delaware is without health insurance. The rate for the 18-29 age group increases 23.5%. Then the rate falls nearly in half to 13.2% for the 30+ age group. Those in the 18-29 age group are a particular problem relative to health insurance for a number of reasons. First, they are new entrants in the labor force and many are in lower paying jobs. Those jobs are less likely to health insurance as a benefit and if they do, the employer will require a 50% contribution by the employee. Second some in this group will work for small employers who do not offer even the opportunity for coverage. However, an examination of the data shows that there is very little difference between the 18-29 age group and the 30-64 age group with reference to size of employer. Third, these younger people will be unlikely to take health insurance offered because

they don't see the need for it. The expected value of the cost of health care services is far less than the cost of the insurance.

Among the 86,500 uninsured, 29% are under the age of 19 and 32% are in the 18-29 age group.

Delaware's population is only slightly older than that of the US. Looking ahead, the aging population should help increase coverage if economic conditions do not deteriorate significantly and current employer practices continue.

Family composition. The makeup of the household influences health insurance coverage in Delaware and elsewhere in various ways. A single person household is totally dependent on themselves for coverage. In contrast, most husband/wife households have two possibilities of obtaining coverage. Children within husband/wife households also enjoy the same advantage. Just fewer than 10% of heads of household were uninsured in contrast to spouses of which only 7.2% were uninsured. A person living alone was nearly 40% more likely to be uninsured (14.5%) than a member of a two or four person household (10.5%). An adult offspring or some other relative of the family living in the household were about 2.5 times more likely to be uninsured than the head of household.

Among the 86,500 uninsured, 15% live alone and almost 70% of the adults are single. Considering only the uninsured children, 56% live with two parents while the rest have a single parent/caretaker.

The family composition in Delaware is nearly a mirror of the US in almost every category. The longer-term trend however is not necessarily positive for health insurance coverage. The number of single person households and households with a single adult heading a family both continue to increase while husband/wife households declines. This trend is nearly 40 years old and is unlikely to reverse course as the population ages.

Health status. The best measure of health status for Delaware is found in the Behavioral Risk Factor Survey System. While this only covers the 18 and over population, it is certainly indicative of the general situation in the state. Overall, almost 65% of that population indicated that their health status was either excellent or very good and only 10% classified their health as either fair or poor.

It should be mentioned that the BRFSS measures current status and not the previous 12 months. However, since two thirds of those currently uninsured had not been covered within 12 months it is a good indicator. For those currently insured, 66% classified their health as either excellent or very good. Fifty one percent of those who reported being uninsured similarly classified themselves. Most of that differential was found in the good category although the difference in the fair/poor category was noticeable 12.4% compared to 9.9%.

In examining health status of Hispanics and African-Americans there were somewhat different results. In general, African-Americans tend to be significantly less positive about their health status than Caucasians. Hispanics were only slightly less positive than non-Hispanics about their health.

While the way of measuring the uninsured differs between BRFSS and CPS, the relationships are similar and Delaware's health status is about the same as that for the US in the CPS.

Employment status. Excluding for the 11.2% who are uninsured, Delawareans obtain their health insurance in a variety of ways. First, government programs insure some 28% of Delaware residents. Second, another 9% are covered through some type of government employment. Third, large (500+ employees) businesses that primarily self-insure cover 28% of Delawareans. Smaller businesses cover 18% of the state's residents and the balance (6%) is covered by individual market policies.

Since 69% of adult Delawareans that are uninsured are also working and the roughly the same proportion are single, they will only have insurance if they buy it or their employer offers some type of benefit. Many of these people are working in either part-time or low paying jobs where the employer either does not offer coverage or will pay only 50% of the premium which is significant to a person making $10 per hour.

The percentage of uninsured in Delaware varies considerably by industry. The lowest percentages are found in the declining manufacturing sector (9.5%), which also has the highest average wages. The worst percentages are found in the construction industry (25.8%) followed by wholesale and retail trade (19.3%). The financial sector and the service sector tend to coalesce around 12%. Unfortunately, the most highly paid and unionized portion of the employment market is also the one in decline.

Even working for the government does not guarantee health benefits where 7.7% of employees are without. Typically, these are classified as "temporary seasonal" employees and they do not qualify for health benefits.

Small firms with 25 or fewer employees have nearly three times the percentage of uninsured (29%) compared to firms with 1000+ employees (11.8%). Larger employers usually offer higher wages and thus the cost of the benefit package is not as significant as it would be for a smaller firm. These percentages have not changes at all during the economic expansion of the 1990s. The only discernible pattern has been a 1% increase in the rate for the 1000+ employee firms from 10.9% to 11.8%.

Among the 86,500 uninsured roughly 28,000 are adults working for firms with less than 100 employees and 19,000 of those work for firms with 25 or fewer employees. These numbers do not include any dependents of these individuals who presumably are not covered as well.

Availability of private coverage. The indicator used for suggesting the availability of private coverage is the percentage of the population covered in this manner. The current estimate for Delaware is 7.2%. In contrast the US average was 10.2% for 2000. The most likely reason for the difference is probably income levels although an analysis of that idea was not convincing. In Delaware, the incomes of those families with private insurance averaged $76,000 or 55% greater than the income of the average family. In contrast, the average for the US having private insurance was $66,000 or about 39% higher than the US average family income. Both measures show substantially higher incomes are needed to purchase private insurance. Since the income level is

substantially higher in Delaware, it could suggest that these rates are higher in this state. It could also reflect differences in the coverage options within the state versus the US.

Race/ethnicity. During the past five years lack of health insurance among Caucasians has hardly changed with the 12.1% in 1995 and 11.7% in 2000. There has been some improvement within the African American population where the rate has declined from 21.8% in 1995 to 16.3% in 2000. Still the rate for African-Americans is 40% higher than for Caucasians. For those of Other/Mixed races the difference is even larger (25.7%) and is stable over the entire period.

A larger difference exists between the Hispanic (27.7%) and non-Hispanics (12.5%). This difference has been reasonably consistent over the period and if anything, has grown larger.

The uninsured population of 86,500 is 68% Caucasian and that is slightly less than the proportion in the total population (74.6%). On the other hand the uninsured population is 10% Hispanic compared with 4.8% in the population as a whole.

The lack of health insurance in Delaware compared with the US is less prevalent and that holds true for the major race and ethnic groups discussed here. This is important since Delaware's race/Hispanic profile is different from the US. Delaware is 19.2% African-American compared with 12.3% for the US. In contrast Delaware has 4.8% Hispanic residents compared with 12.5% in the US. The trend for both Delaware and the US is toward an even more diverse population. As that occurs, other factors must change with respect to health insurance coverage or the proportion lacking coverage will rise significantly.

Immigration status. Given the fact that almost 60% of Delaware's population growth and more than 80% of Sussex County's growth comes from net in-migration and since a significant proportion is from outside of the US, the health insurance status of these individuals is of particular interest. It has already been noted that Hispanics are over represented in the ranks of the uninsured and that their prevalence in the population is growing. The latest estimates suggest that 12.5% of the native born population (home or abroad) is uninsured. This compares with 18% for naturalized citizens and 41% for non-citizens. The reasons for these differences are numerous and include language barriers, employment issues, and cultural differences.

While Delaware has a lower percentage of uninsured than in the US broadly, the percentages regarding immigration status are similar. The 2000 CPS shows that 13.4% of the native-born population is uninsured. This rate compares favorably with naturalized citizens (17.9%) and non-citizens (42.6%). As immigration becomes even more important to maintain a strong labor force, this percentage of uninsured is likely to rise.

Geographic location. There are significant differences between Delaware's three counties in the percentage of residents lacking health insurance. New Castle County is the most urban/populated and the highest income county in the state. It has consistently the lowest percentage of persons without health insurance, 12%. Sussex County, the county with the oldest population in the state (median age=41.1 years), is next with 13.4% and Kent County, with the youngest population (median age=34.4 years), is last with 16.4%. However, the picture changes if you only consider

adults 18-64. Using that metric, Sussex County fairs worst with a larger percentage of its population being covered by Medicare.

In addition, Sussex County has had a significant influx of Hispanic immigrants working in the food processing industry as well as the tourism industry. Probably the most important difference is that the proportion of children without health insurance in Kent and Sussex counties is about double the rate found in New Castle County. Most of these differences can be attributed to the nature of the economies and the resulting income structure in those two areas. Child poverty for example is much higher in those counties for much the same reasons.

Sussex County is the fastest growing county in the state largely due to net in-migration of retirees to the beach areas and then the secondary in-migration to take jobs in the service industry needed by the growing population. However, many of these jobs are associated with small firms who are not likely to provide health insurance. In addition, the in-migration of Hispanics continues and some within that population are less likely to use government programs such as Medicaid even if they are entitled to do so.

In Kent County the problem is somewhat different. The economy continues to grow very slowly and the types of jobs being created tend not to be at the higher end of the wage spectrum. With the exception of those provided by government many of the jobs are provided by smaller firms.

Duration of uninsurance. In the 1998-2000 BRFSS, almost 24% of adult Delawareans were without health insurance for less than six months. Another 14% are without health insurance for from 7-12 months. The remaining 62% have been without health insurance for a year or more or have never had health insurance at any time. These results are very similar across all three counties in Delaware.

Another way at looking at this problem using the CPS data is to match individual households in the sample across years. Using that approach one can see how many persons who were uninsured in the first year became insured in the following year. More than 51% of the uninsured in the base year become insured at some point in the next year. These results are slightly better for children (52%) than for adults (47%).

Health insurance status can change for a variety of reasons. Among the reasons are changing employment status, jobs, marital status, and/or poverty status. Probably one of the most disconcerting findings is that amount of time one is uninsured seems to be insensitive to the economy. As the economy has grown over the decade the percentage of uninsured has increased and the duration has been reasonably stable.

Access to Insurance Coverage

Underinsured. The concept of being underinsured is not a simple computation. It involves the amount of risk an individual is willing to take given the expected cost for healthcare that is likely to be needed and the ability to pay that cost. For example, a typical 25 year-old male has three chances in 100 of requiring a hospital stay and the typical charge for that stay would be $5000. Thus, the expected outlay would be only $150. A typical 50 year-old male has one chance in ten of needing a hospital admission with a typical charge of $11,000. The expected outlay for that person

would be $1100. The calculus at that point becomes a comparison of the insurance cost against the expected benefit.

The other side of the equation is the ability to pay the bill out of current or future disposable income if the individual is "unlucky" so that the charges do not become uncompensated care. Our typical 25-year might have difficulty paying the $5000 bill out of a $25,000 annual income even if scheduled over several years. That would not be the case if their income were $50,000. This leads to the conclusion that you are probably underinsured if you cannot pay the cost of the average hospital bill that a person like you might incur. If one assumes that a reasonable amount to pay for healthcare is 12% of income, then the 25-year old that has a catastrophic policy with a $3000 deductible is not underinsured. They would probably be unwilling to pay for 50% of the typical health insurance policy offered by a small employer for $100 per month. Technically, they might be considered over-insured.

Another way of looking at this or at least an indicator as to the level of the underinsured in Delaware is found in the BRFSS. Respondents were asked if they had needed a doctor but couldn't afford one. As expected, there was a fairly large group within the uninsured, some 33.5% and this held across the three counties. However, even among the insured 5.2% replied that they had been in that situation. It is probably not too risky to assume that these people could not afford to pay the bill out of pocket and also did not have coverage. They might be classified as underinsured.

Willingness to pay. Every individual has some willingness to pay for health insurance. It depends upon current income, the expected benefit in terms of out-of-pocket costs avoided, and the cost of the package being offered. The best indicator available may be the US Bureau of Labor Statistics Consumer Expenditure Survey that measures out-of-pocket expenditures in a wide variety of categories including healthcare. According to that survey, people are paying between 3% and 4% of their disposable income toward healthcare and that includes the employee share of any health insurance. Those percentages rise with age until age 55. Until then the increased outlays are offset by increased incomes. After age 65 the outlays are constant but tend to be between 10% and 12% of incomes. Since Delawareans in general tend to pay a smaller share of total income for healthcare than the US on average, one might expect "willingness to pay" to tend toward the lower end of the range.

Minimum benefit. The concept of minimum benefit plans is difficult to discuss without deciding what one is trying to accomplish. If the idea is to get employer's to offer a low cost package (rather than nothing), there is still the problem of getting the employee to accept it. If the benefit were such that the individual could pay for it out-of-pocket if health care is needed, then why would they pay their share of the employer plan? If the package is so "bare bones" that it would cover doctor visits but not laboratory charges and generic prescriptions, it might not be considered very attractive. One alternative starting to be used by some employers is the medical savings account coupled with catastrophic coverage. If the medical savings account or a "use it or lose it" account was set close to the annual average expenditure mentioned above or perhaps 80% of it, that might be defined as a minimum benefit plan.

Lack of participation. Participation is a function of several variables. First, there has to be opportunity to participate. If working for an employer that does not offer a health plan or if unemployed there is no opportunity to participate. Second, the cost may be prohibitive because of

the size of the employer's contribution and/or the employee's required contribution relative to their wages. Even if the employee is covered, the cost of covering the rest of the family may be prohibitive. Increased participation requires a series of strategies, which encourage employers to offer health insurance of some type. Further, any strategy that would reduce cost to within reach for both the employer and the employee will increase participation. In Delaware, the single person who is employed full-time is representative of one-third of uninsured adults and may not be participating for one of the reasons listed above. Another 36% of the uninsured are single adults who are either employed part-time or not at all. To that one must add the 16% consisting of married head of households and spouses who are working full-time but are not participating for one of the above reasons. The balance of the adult uninsured is either unemployed or is working part-time. In many of these cases the best route to increased participation is opening up the SCHIP program to uninsured parents of the current program participants. This possible strategy is discussed further in Section 4 of this report.

Role of employers. Employers in Delaware provide healthcare to nearly half of the residents of the state. Small employers are the most difficult problem area and discussed in detail in Section 2 of this report. For the most part these businesses employ people who are being paid in the $6 to $12 range. Many are in the retail or service sector and do not have high profit margins. Many of the employees are able to get health insurance elsewhere through a spouse's employer or simply do not want to pay or cannot afford to pay the typical 50% contribution required by the employer.

Over the next ten years it would be reasonable to expect more resistance to increasing health care costs and the introduction of more flex accounts, medical savings accounts, defined contribution plans, and other changes that will limit the exposure of the employer and increase the participation of the employee.

Public programs. Delaware offers a number of programs for those who cannot reasonably be expected to pay for a typical health insurance policy. These are listed below:

- Pregnant women and infants under 1 year of age at or below 200% of poverty;
- Children age 1-5 with a family income at or below 133% of poverty;
- Children age 6 through 19 with a family income at or below 100% of the poverty level;
- Uninsured adults in the expanded population with incomes at or below 100% of the poverty level;
- Children in the Delaware Healthy Children program ages 0 to 18 must have incomes at or below 200% of the poverty level.
- A Qualified Medicare Beneficiary must have an income at or below 100% of the poverty level;
- A Specified Low Income Medicare Beneficiary must have an income at or below 120% of the poverty level;
- A Qualified Disabled Working Individual must have an income of at or below 200%.
- There are other special circumstances of coverage for individuals who fall within certain federal poverty levels; e.g. transitional Medicaid and/or those receiving SSI benefits.

Section 2. Employer-Based Coverage

Information Gathering Method

The Census Bureau's Current Population Survey was the source of social and economic characteristics and the uninsured status of Delaware's residents. The data in the CPS is collected nationwide and for Delaware contains a sample of 700 households, which usually represents about 1400 people. Demographic and economic characteristics for the uninsured were identified from the Current Population survey for the uninsured population.

A large proportion of the uninsured in the state of Delaware are employed in companies with less than 50 employees. These companies represent the largest growing segment of Delaware's economy. Efforts were concentrated on employees of small and medium size businesses. The 2000 Small Employer benefits survey by Blue Cross Blue Shield, Employee benefits Research Institute and Consumer Health Education Council was used as a basis for the design of a survey instrument administered to employers of these individuals. The survey was developed to find out the reasons why small employers in Delaware with less than 50 employees do not offer health insurance.

The survey instrument consisted of two separate questionnaires. One to be filled out by businesses that offer health insurance to their employees and the other by businesses that do not offer any health plans to their employees.

The questions in the questionnaire were divided into three distinctive groups:

- Attitudes towards offering health plans to employees
- Information about the business (such as number of employees, full time/part time status, annual earnings,)
- General knowledge of the health insurance market

The sample size of the Small Employer Health Insurance survey was 1598 providing appropriate representation by county. The surveys were sent out in 4 separate mailings over a period of 2 months. The response rate for the survey was nearly 50 percent. The data gathered was weighted to appropriately represent the population of small businesses in the state of Delaware. A full report of the Employer Survey process is provided in Appendix B.

Characteristics Of Firms That Do Not Offer Coverage Compared To Those That Do

More than half (62 percent) of Delaware's small businesses not offering health insurance have 1 to 5 employees, 32 percent of small businesses have 6-15 employees, 4 percent have 16-25 employees and 2 percent have 35 to 50 employees. Small businesses offering health plans tend to have more employees, 32 percent of them have 1-5 employees, 45 percent have 6-15 employees.

In terms of gross revenue 75 percent of small businesses not offering health plans have gross revenues less than $500,000 (this is where the median is), 15 percent had gross revenues between $500,000 to $1million. Among small businesses offering health plans the median gross revenue is between $500,000 to $1 million.

The typical full time salaried employees median income for the companies not offering health insurance is $25,000, and the median wage for hourly employees is $9. For firms offering health plan the median income for salaried employees is $30,000 and the median wage is $10.

Only around 6 percent of businesses surveyed are extremely likely or very likely to start a health plan for their employees.

One quarter (24 percent) of businesses not offering health plans are family owned businesses compared to sixty percent of firms offering health plans.

Three quarters of small businesses not offering health plans have owners, who are covered by a health plan, compared to ninety percent for businesses offering health plans.

The average turnover rate for a business not offering health plans is 24 percent compared to 13 percent for businesses offering health plans.

The median part time employment is about 33 percent for firm's not offering health insurance contrasted with 10 percent for businesses offering health plans.

Small businesses without insurance are 3 years younger than businesses with insurance (median age of 10 compared to median age of 13).

Ninety percent of the businesses not offering health plans indicated that their employees do not belong to a union compared to 97 percent for business with health plans.

In terms of the gender of employees the medium business not offering health plans have an even distribution of males versus females while businesses offering health plans have 40 percent females and 60 percent males.

The medium business not offering health plans has about 20 percent employees under the age of 30 compared with 17 percent for those with health insurance.

Factors Influencing Employers' Decision To Offer Health Insurance

General Knowledge Of The Insurance Market

The top three reasons for not offering health insurance are: 1) The Business cannot afford it (72 percent), 2) Employees cannot afford it (56 percent), 3) Revenue too uncertain (55 percent). A significant proportion (37 percent) of employers have indicated that a major reason for not offering health insurance is that employees have coverage elsewhere.

The three most important reasons for offering health plans are: 1) It is the right thing to do (66 percent), 2) It helps with employee recruitment (55 percent) and 3) It increases loyalty and decreases turnover (48 percent).

More than half (53 percent) of the businesses not offering health insurance have stated that they feel that they have a large obligation or some obligation to provide health insurance to their

employees. One third of the companies feel that they have no obligation to provide health insurance coverage.

Only a fifth of the businesses agree that not providing health coverage has impacted their employee recruitment, retention and performance. Businesses that offer health benefits are twice as likely to believe that these are important.

Among those who do not offer health plans a fifth offered this benefit in the past five years. Among those who offer health plans today 66 percent switched to or got their current health insurance within the last 3 years.

Around 55 percent of small businesses without health benefits have contacted someone over the last two years for information on health insurance.

On the series of true and false questions business that do not offer health plans tend to get the right answer 58 percent of the time compared with 64 percent for those businesses that offer health insurance.

Cost Of Health Insurance

The median small business not offering health plans expects the cost to cover one employee for one year to be $4,800. Businesses offering health plans suggest the cost of $2,545 annual cost per worker.

Of those businesses that provided an estimate, the median annual contribution they would be willing to pay was around $900.

In general, businesses not offering health plans overestimate the cost (reported by businesses who offer this benefit) by almost 90 percent. The suggested median contribution they would be willing to make would cover almost 40 percent of the actual cost to insure a worker for a year. The median business offering health plans covers 100 percent of the employee only cost and 20 percent of the dependent cost.

Incentives To Offer Health Plans

Almost half (46 percent) of small businesses would more likely consider offering a health plan if government provided assistance with the premium.

The medium government assistance needed in order for the business to provide health plan was 60 percent (based on the over estimated cost of health insurance).

The top three factors that would most likely make the businesses seriously consider offering a health plan are: If there was an increase in business' profit (76 percent), If employees asked for it (70.5 percent) and If it could be demonstrated that it would improve recruitment and retention.

Eligibility And Participation

Employee eligibility (for both full time and part time employees) varies considerably among businesses in Delaware. More than 80 percent of small businesses offering health plans consider all their full time employees eligible. All part time employees are considered eligible by 10 percent of firms.

The median small business in Delaware offering health plans to employees considers 100 percent of its full time employees eligible. On the other hand it does not consider any of its part time employees eligible.

Also the participation of eligible employees varies across small businesses. Only a third of all firms have all 100 percent of their employees participate in their health plan. A quarter of the firms have participation rates between 75 to 99 percent.

Less than a fifth of all firms have a 100 percent participation in their dependent coverage programs for eligible employees. Less than a tenth have a participation rate between 75 and 99 percent.

One third of the businesses surveyed require their eligible employees who opt not to participate in the firm's health benefits to demonstrate that they have coverage elsewhere.

Qualitative Research

The health policy vendor conducted focus groups of employer/business owners and employees. The results of that process largely concur with the findings obtained through the survey process. It is important to note that focus group participant recruitment was inordinately difficult and participation was minimal. A focus group summary report is included as Appendix C.

Section 3. Summary of Findings: Health Care Marketplace

Marketplace Findings
If "adequate" is defined as accessible and affordable, there are wide differences in accessibility and affordability of existing insurance options based on income levels and pre-existing conditions (if coverage is sought in the small group or individual insurance markets).

Variability Based on Income Levels
Based on the eligibility levels for public programs in the state (Medicaid and SCHIP), low-to-moderate income level individuals or families may not have access to affordable health insurance coverage. Currently, eligibility levels for Medicaid are as follows:

Pregnant Women & Children Up to Age 1	200% of the Federal Poverty Level
Children Age 1 – 6	133% of the Federal Poverty Level
Children Age 7 – 19	100% of the Federal Poverty Level
Adults (non-disabled)	100% of the Federal Poverty Level
Elderly and Disabled	250% of the Federal Poverty Level

The Delaware Healthy Children Program (S-CHIP) is operated as a separate, non-entitlement program, but dovetails with Medicaid, offering coverage to children in families with incomes up to 200% of the Federal Poverty Level.

Adults (non-disabled) with incomes above 100% of the Federal Poverty Level ($8,590 in 2001) may not be able to afford health insurance unless their employer provides coverage with no or minimal employee contributions. The same may be true for children in families above 200% of the Federal Poverty Level.

To illustrate the problem, one of the participants in our focus groups for employees of small businesses indicated she had applied for Medicaid (because her employer did not offer coverage), but was denied because her income was slightly above the eligibility level.

Variability Based on Pre-Existing Conditions
Based on the information provided in consultant conducted key informant interviews, the private health insurance market in Delaware is stable, but with great variability for those with pre-existing conditions, based on employer size.

The state passed the NAIC small-group model (modified so that it applies to groups as small as one). But, both small groups and individuals are medically underwritten, which results in unaffordably expensive premiums for high-risk applicants and dramatic rate increases for individuals who develop serious conditions when they try to access coverage through the small-group or individual markets.

Community Assessment of Marketplace
Participants in focus groups conducted with small business owners and employees of small businesses, indicates that the single most important barrier to offering health insurance is cost. While overall rates are high, rates also vary widely, based on the health condition of employees, due to the medical underwriting for small group insurance policies. Thus, for those with pre-

existing conditions, or those who experience the on-set of a serious or chronic illness, affordability becomes a major barrier.

Focus group participants expressed concern over two primary issues, both related to cost; 1) the medical underwriting of small groups, and the dramatic premium increases when a member gets sick. (One participant reported that when her husband had to have a pacemaker, their premiums increased from $847 per month to $1,400 per month, but she could not change plans because of the pre-existing condition.), and 2) the high, and increasing, cost of prescription drugs.

Reforms

In recent years, reforms in the small-group market and the individual market have stalled, with most legislative changes involving mandated benefits – "the state has enacted 13 to 17 mandates in the last five years." Each mandated benefit applies only to a portion of the insurance market – generally to small-group policies, state-sponsored policies, and individual insurance policies, thus increasing premiums for these populations. Under federal law, ERISA plans of self-insured employers (which includes most large employers) are exempt from mandated benefits and other legislative changes.

Seventy-five to eighty-five percent of the Delaware health insurance market is covered by ERISA plans of large employers. Because the market is significantly skewed to ERISA plans, there is "no law of large numbers" for small group and individual insurance carriers attempting to spread risk.

The Commission oversaw completion of a comprehensive study of individual market health insurance reform in 1999. Findings from that process are considered current and valid. With various policy issues in mind, four illustrative reform models were developed. The results of this process were disquieting in that the models ranged in cost from $180,000.00 to $3,200,000.00 and the maximum number of covered lives to expect was 1800. Recommendations were not put forth to the General Assembly.

All six hospitals in the state are non-profit, with limited competition and little incentive to negotiate with managed care players (especially one large hospital system). The result is that premiums for small groups are high (compared to the region) and are increasing significantly each year. Because of the slowing economy and increased costs, many small businesses are dropping coverage. Recent national events have left insurers unable to recoup underwriting losses in a bad stock market. Workman's compensation premiums are going up, creating even more of a hardship for employers at a time when consumer spending is down and affecting employer revenue.

Because Delaware is a relatively small state, the state is significant as a purchaser of health care. Although some thought has been given to using the combined purchasing power of the various elements of state purchasing—Medicaid, S-CHIP, and the state employees' plan—there are significant barriers to accomplishing this. The state as an employer has not seen itself as having the expertise to do the kind of negotiations and contract that Medicaid does. In addition, many people have reservations about approaches that could be perceived as somehow merging the state employees with the recipients of Medicare and S-CHIP.

Method for Obtaining Information
As part of our research to document the extent and nature of the problem of the uninsured in Delaware, our health policy vendor conducted eight telephone interviews with state officials and other knowledgeable persons; e.g. the State Chamber, the Insurance Commissioner, and the Health Care Association (hospitals). The telephone interviews were conducted from May 3-11, 2001. The discussions were conducted around a series of questions regarding the private insurance market in Delaware, the publicly funded health coverage programs, and locally based health coverage initiatives. The health policy vendor also completed focus groups with employers/business owners and employees on May 30-31, 2001.

In regards to information gleaned from other states, we shared an active dialogue with not only other HRSA Planning grantees, but most importantly with representatives from a public-private partnership in Michigan. Research indicated similarity in the approach taken by the Muskegon County, Access Health initiative to one of the options generating significant interest from our stakeholders. We felt fortunate to learn of the Muskegon County projects trials and tribulations through a site visit conducted in August 2001. The experience of other states was additionally a part of our agenda at each of two policy conferences discussed further in Section 5 of this report.

Impact on Policy Deliberations
Assessment of the marketplace has resulted in two important themes that have emerged as cornerstone to our ongoing policy deliberations: the importance of employer education, and the critical role of the safety net.

Based upon our research, information gathering, and consensus building strategies it became apparent that small employers have a variety of information needs. Misunderstanding of the costs of benefits, the tax treatment of benefits, how to compare and evaluate policies, and how to work with brokers were messages heard repeatedly. Accordingly, our continued planning and policy deliberations will strive towards the development of educational information, clearinghouse concepts, and strategies for how to best disseminate this information and information about existing or new resources and tools.

Not any less importantly, we have found through research and experience as a Community Access Program grantee overseeing the Delaware Community Healthcare Access program, that for some individuals the term or concept "insurance" has little to no meaning. For these individuals, the presence of a strong safety net is critical. Ongoing policy deliberations will focus on how to best support and strengthen the Delaware safety net.

Section 4. Options for Expanding Coverage

The Process for Considering Options
Before beginning to deliberate on the range of possible options, the Commission identified a list of criteria to guide their work. The criteria are as follows:

Other things being equal, preference should be given to policies that do the following:

- Are administratively doable and practical in a small state.
- Can generate sufficient political support from Delaware citizens, elected officials, the business community, health care providers, and health plans and insurers.
- Are affordable in terms of the state budget.
- Maximize use of federal dollars rather than state dollars.
- Extend coverage to lower income people before higher income people.
- Produce the highest ratio of people covered per state dollar spent.
- Minimize replacement of private coverage with public coverage.
- Are equitably financed.
- Build on successful existing institutions and administrative structures rather than requiring entirely new institutions and structures.
- Do not depend heavily on changes in federal law or regulations.
- Do not create disincentives to work.
- Minimize social stigma and maximize personal dignity.
- Create incentives to economize on the use of costly medical resources.
- Achieve immediate benefits rather than postponing coverage extensions to a point further in the future.

It was recognized that no policy could score well with respect to all criteria but nevertheless concluded that it was important to keep the criteria in mind in choosing among policy options.

Background Conclusions
Deliberations led to a series of observations about the problem that were also important in guiding the "options" dialogue.

- The preponderance of the uninsured are members of working families with incomes between 100 percent and 200 percent of poverty—those with incomes between approximately $17,500 and $35,000 for a family of four. This group represents the highest priority target population.
- For these people, the challenge is to make coverage affordable. Given that good family coverage probably averages over $6,000 per year in Delaware, these families typically cannot afford to buy coverage on their own, and they often work for employers that do not provide coverage. Such families will have great difficulty affording coverage without subsidies.
- Since subsidies will be necessary to make coverage affordable for some of the uninsured, the federal and/or state governments will have to support new financing or extensions of existing public programs if the problem is to be solved.

- There is often a tradeoff between two desirable objectives—keeping budgetary costs down and treating people equitably. To limit costs, it is often necessary to design policies that minimize "crowd out"—which occurs when people who already have private coverage become eligible for new public programs and drop their existing coverage. Such switching would add to the cost of the program without increasing the extent of coverage. But imposing crowd-out prevention policies means that people in essentially equal circumstances are treated differently: those who had no previous coverage get aid, while others who are no better off financially but are already bearing the burden of financing their coverage get no aid.
- We acknowledge that, given present federal policies, state government cannot fully solve the problem of the uninsured in Delaware. The state can make significant progress, but achieving nearly universal coverage is an unrealistic objective for the state acting alone. It is no accident that no state has been able to accomplish this worthy objective. Overcoming the affordability problem to ensure universal coverage requires resources and authority that are beyond what Delaware, or any state, can provide without substantially more federal financing and new federal legislation.

Options Recommended for Further Development

Discussed below are a set of options that felt sufficiently promising that they deserve further development in order they might be ready for final consideration and possible implementation when the state's fiscal situation makes that practical. (The full range of options considered is provided in Appendix D.) We recognize that there is some overlap among the options in terms of the people who would be helped to get coverage. Adoption of one or more of the options might make adoption of some of the others ultimately unnecessary. It is unlikely, however, that all of these options would be implemented simultaneously, so there would be time to evaluate the effectiveness of options in place before initiating others.

For each of the options, information is provided about the general approach, the target populations, and the advantages and disadvantages. Cost and likely impact on the number of uninsured are found in tabular format for each option with Appendix E. The cost and impact estimates are based on detailed actuarial work, although only summaries of those estimates are provided below. The more detailed analyses for the options, along with the underlying assumptions, are available in Appendix F. It is important to recognize that the cost and impact estimates are made with the assumption that no other option has been put in place. Since there is some overlap in the target populations, the estimates would need to be recalculated if more than one option were implemented. The cost estimates are in year 2000 dollars.

Safety Net Support: Limited Benefit Plan Approach

<u>Approach</u>

While the Diamond State Health Plan covers all individuals in families with incomes less than 100 percent of the poverty level, many individuals with slightly higher incomes are without health coverage and struggle to pay for non-emergency services. The approach outlined here is designed to help this group. It is proposed as a complement to the Commission's Delaware Community Healthcare Access Program (funded through the HRSA CAP) that was recently implemented as a way of broadening and strengthening the "safety net" system that supplies care to people without

insurance. This limited benefit plan is viewed as a mechanism for helping to fund some of the ambulatory services that the safety net providers provide.

People who make up the target population for this approach will usually seek and receive emergency and urgent care, often as charity care of a hospital system. But sources of ambulatory care are less readily available, and many of the people in this income group simply go without getting such care. Under this option, low-income individuals who are not eligible for Medicaid or S-CHIP would be allowed to enroll in a program which would cover primary care (which is capitated), specialty care (which is prior authorized), laboratory and radiology (contracted with specific providers), and prescription drugs (with a formulary that is restrictive and includes primarily generics). Hospital care is not covered. If enrollees require acute care, they fall back to the safety-net system on which they previously depended for *all* care. Usually, there is no premium or deductible and only nominal copayments for office visits and prescription drugs. Limiting the scope of benefits reduces the chance that this program will lead individuals eligible for employer-sponsored coverage to forego that option and instead choose the limited benefit program. Limiting the level of income for enrollees also reduces the chance that individuals who can afford to purchase employer-sponsored coverage will forego that option and instead choose the limited benefit program.

Communities in several states are developing or have implemented programs of this sort. An example is the Ingham Health Plan in Ingham County (Lansing) Michigan. The plan provides primary and preventive care for over 12,000 county residents with incomes less than 250 percent of the FPL

Target Populations

The target population would be people above the Medicaid eligibility level, that is, individuals age 19 to 64 with incomes between 100 percent and 200 percent of poverty, without regard to employment status. Employed individuals are included because many people in this income category work for employers who do not offer health insurance, or, even when they do, the coverage may be unaffordable. A person would not need to be a parent of a minor child to be eligible.

Advantages

This approach has several advantages over subsidized approaches that offer more comprehensive benefits. Because the benefit package excludes acute care coverage, the subsidy dollars go further: that is, a defined budgetary allocation produces coverage for more individuals. Another advantage is that the benefit package encourages use of primary and preventive care—before illness becomes serious, chronic, or costly. Finally, the safety net providers that are crucial to providing care for many low-income people, such as those participating with our CHAP program, can receive some payment for the services they provide, which should help to maintain their participation and thus provide continued access to care for this population.

Disadvantages

The disadvantages of this approach are fairly obvious. The approach continues to rely on hospitals to fund the cost of acute care for the uninsured (in part through cost-shifting). The program could also cause some crowd-out: the availability of ambulatory care without premiums may deter some

low-income employees from accepting employer-sponsored coverage that requires an employee contribution. The need-based character of the system is different from standard insurance and adds administrative complexity related to determining eligibility and may create a stigma associated with the requirement that applying households disclose their income. Finally, unless special and rather complicated steps are taken to make the program fundable under Medicaid, the only source of funds is the state budget.

One-Third Share Plan

The Approach

The One-Third Share Plan is a subsidized coverage program with more limited benefits than a typical comprehensive plan so that the premium for employers and employees can be kept low enough to make the plan financially attractive (in the range of $1,500 to $1,800 per year). Examples of limitation on benefits from existing programs include exclusion of dental, vision, hearing and speech services, outpatient physical and occupational therapy, durable medical equipment, as well as pharmacy formularies that primarily cover generic products, and coverage for only a limited number of inpatient hospital days. Coverage is offered to employers of low-wage workers who have not offered coverage for the last year or more. As proposed here, the premium would be shared equally among the employer, the employee, and government, with each paying between $40 and $50 per month. Experience suggests that the $50 level seems to be a threshold above which a substantial proportion of employers and employees are likely to decide against buying coverage.

Communities in several states are developing or have implemented programs of this type. Most of these programs include government subsidies that cover one-third of the cost of health care services for employees and their dependents. The largest of these programs is Health Choice in Wayne County (Detroit) Michigan and currently covers around 22,000 employees and their dependents in 2,200 businesses. The Health Choice program is relatively comprehensive but does not include all of the benefits required under Michigan's insurance laws. Some of the programs currently under development will subsidize licensed insurance products.

Target Population

This approach is designed to aid employees (and their dependents) who work for low-wage employers that would not otherwise offer coverage because they cannot afford to contribute toward the premium of a typical comprehensive plan.[1] To be eligible, firms would have to meet the standard for being a low-wage firm (for example, if their median wage is $10 per hour or less) and could not have offered health insurance for some immediately preceding period (for example, the previous year). Eligible employees would be those who are not eligible for Medicaid, Medicare, or other public programs and who work a defined number of hours per week (for example, at least 20 hours).

Advantages

The purpose and major advantage of this approach is to make coverage more affordable to individuals and families that have not been able to afford it in the past. Without this option their

[1] Insurers typically require that the employer contribute at least 50 percent of the premium. This provision reduces the likelihood that only high-risk individuals will opt to accept coverage.

only alternative would be to pay the full cost of individual coverage, since their employers did not offer coverage. It offers an advantage over publicly funded programs for the same population because a portion of the funding is financed by the employer, thus allowing a given amount of public funds to cover more people. Because these people would now be covered by insurance rather than having to pay for care entirely out of pocket, it is reasonable to expect that they will receive preventive and primary care services that reduce the likelihood of needing more acute care services later.

Disadvantages

Some legal problems could arise if state law requires a minimum benefit package that is more comprehensive than that offered under this plan. Even if the new plan is not in technical violation of the law, some people may object to allowing the distribution of any "insurance" product that does not conform to the mandated benefits requirements. The law may also require that "premiums" be collected only for licensed insurance/HMO products.

Making such coverage available does not ensure businesses will take advantage of it. Achieving a high take-up rate will require intensive effort to sign up businesses. The approach also involves the inequitable treatment that is a consequence of the crowd-out provision: low-wage firms that already offer coverage are denied the opportunity to participate in the program, even though they may be no less "needy" than similar firms that are eligible. This could create an artificial competitive advantage for the subsidized firms relatively to their competitors who are not eligible for the program.

S-CHIP Expansion to Include Parents

Approach

In Delaware, all individuals with incomes less than 100 percent of the federal poverty level are eligible for Medicaid coverage under Delaware's current 1115 waiver. Children in families with incomes between 100 percent and 200 percent of poverty level are covered by Delaware's S-CHIP program, but adults beyond 100 percent of poverty are not eligible for public coverage programs. Because it has unused S-CHIP funds, Delaware could seek a S-CHIP 1115 waiver to extend coverage to parents of S-CHIP children when family income is between 100 percent and 200 percent of the poverty level.

This approach seems especially attractive in light of very recent changes in the federal requirements for implementing this approach. The new waiver authority promulgated as the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative by the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) allows flexibility in development of the scope of benefits and the amount of beneficiary cost-sharing (such as copayments and premiums). Other restrictions continue in effect, but these should not represent significant barriers for Delaware: cost sharing must remain within allowable limits, and higher-income income individuals may not be covered before lower-income individuals.

In addition there are general requirements that a state's current S-CHIP program must meet before a waiver request will be considered. Delaware appears to meet all of these:

- At least one year of experience providing health assistance under S-CHIP.
- Submission of all required evaluations and reports.
- Coverage of children up to at least 200 percent of the FPL.
- Statewide operation.
- Open enrollment (no waiting lists).

There are also requirements for extensive public input in developing the waiver plan. And the state must also demonstrate that it has made an effort to enroll eligible children in its S-CHIP program.

Target Population

The target population for this approach is *parents* of minor children in families with incomes between 100 percent and 200 percent of poverty. Children in these families would not be newly eligible because they are already eligible for Medicaid or S-CHIP. In fact, it is likely that implementing this program would result in reaching additional children that are eligible for by not covered by Medicaid or S-CHIP. Unlike Delaware's Medicaid 1115 waiver, this program would exclude single individuals, childless couples, and parents of adult children.

Advantages

A major advantage of this approach in terms of cost to the state is that the federal government would pay 65 percent of the cost of coverage to the extent that Delaware has any unused S-CHIP allocation. As of 09/30/01, Delaware's unused S-CHIP allocation is approximately $30 million dollars. This figure is however subject to a November/December recalculation and adjustment of the 1999 dollars, as a result of a BIFA authorized change in the 1998 and 1999 formula.

This approach also allows Delaware to finance an expansion of coverage with federal funds while still being able to limit its financial obligation: under an 1115 waiver, the state can "close" enrollment as a way of capping its financial liability. Federal law permits state to close enrollment for optional expansion groups at any time and re-open enrollment when the number of enrollees drops through attrition. This contrast with expansions under Medicaid, which become an "entitlement." Other advantages include the efficiency of being able to use an existing administrative structure rather than having to create one anew. And, as noted above, the process of recruiting and enrolling people in this program will certainly result in the identification and enrollment of children already eligible for Medicaid or S-CHIP, thus expanding coverage further.

Disadvantages

As with all reform options, this approach has disadvantages. To the extent that S-CHIP retains any "welfare" stigma, the new program would similarly be stigmatized. This contrasts with options that depend on having the uninsured people secure private coverage that is publicly subsidized. Another element that some would consider a disadvantage, because of the inherent inequities, is the federal requirement that the state impose crowd-out provisions to minimize the shifting of costs from private sources to public sources. Even with anti crowd-out provisions in place, making subsidized family coverage available to significant numbers of full-time working parents and their children would create greater incentives (than child only coverage) for employers and workers to drop existing private coverage.

Cost and Impact on Uninsured

The cost and impact estimates provided here assume a significant number of people who are currently covered through other forms of insurance will switch to the newly available S-CHIP coverage because there is a financial advantage to doing so. We assume that between 11 percent and 29 percent of the currently insured people who become eligible for this new program will make the switch. This represent between 4,800 and 12,100 people, more than the number that will be newly insured (between 2,900 and 7,700). However, because these estimates of "crowd out" are particularly prone to uncertainty, in the tables in Appendix E we provide the usual data, but the first table shows the effects assuming no crowd out, whereas the second gives a picture of the net effects assuming crowd on the order of magnitude just discussed.

Because there is a significant crowd-out effect, some state dollars are spent on people who were already covered by other insurance. Although this could be considered a "waste" of state money in the sense that it does not result in an increase in total coverage, it is important to remember that the people who switch are people whose financial situation makes them just as deserving of aid as the people who took advantage of the program but did not previously have coverage.

Subsidized Purchasing Pool

Approach

The subsidized purchasing pool approach evolved from a preliminary discussion of an option that would permit certain target populations to buy into the state employees' plan. For a variety of compelling reasons, that buy-in option was rejected, but it was recognized that there is a group of uninsured people who have trouble finding affordable coverage but who are unlikely to be eligible for other subsidized programs—in general, employees of small employers and people whose incomes fall between 200 percent and 300 percent of the poverty level. This approach targets this population. It combines some of the elements that were considered when the state employee plan buy-in was still on the table with elements of a purchasing cooperative.

While this option deserves further consideration, even more than the other options detailed here, it is an approach that has many implications and many unresolved issues that would need to be addressed before a plan for implementation could be developed.

The basic idea is to establish an entity, under state auspices, that would act as a purchaser of health coverage, negotiating with carriers and health plans on behalf of the target populations and then offering a choice of all the selected health plans to eligible employers and individuals. The expectation is that the total purchasing power of the state (resulting from its contracts with health plans for Medicaid and the state employees' plan) could provide effective leverage to negotiate contracts that would include favorable terms, thus ensuring that people who enroll would get more affordable, high-quality coverage.

One variation would have the health plans price the coverage on the assumption that those enrolling would be an average-risk population. To the extent that the enrolled population was an above-average-risk population, the state would absorb some or all of the cost of this adverse selection. Another variation would go beyond this form of subsidization and also make coverage

available with steeper subsidies, for example, with the state subsidizing one-third of the premium and employers and employees each paying one-third.

The process would include the following elements:

- Carriers would submit bids to provide a defined comprehensive, but not rich, benefit package, assuming a normal-risk population would enroll.
- The purchasing pool would negotiate with carriers and ultimately decide which health plans to offer, depending on the value.
- The state, rather than insurers, would absorb some or all of the cost of adverse selection and perhaps provide additional subsidy.
- Employers would pay a minimum of 50 percent of the premium if there were no direct state premium subsidy, if there were a direct subsidy, the assumption (for the cost examples below) is that the state would pay one-third, and employers and employees would each pay a third.

Target Populations

The primary target population is anyone (an employee not offered employer-sponsored coverage or an individual) with household income below 300 percent of poverty (approximately $53,000 for a family of four or $26,000 for a single-person household). Also eligible would be low-wage firms with a median wage of $10 per hour or less. In addition, since small employers have a particularly difficult time getting affordable coverage, any firm with 10 or fewer employees would be eligible to participate. (All parameters are for illustration and estimating purposes only; subject to change if this approach were to be further developed.)

Advantages

The main advantage of this approach is that it offers normal-priced coverage to populations that often have to pay substantially more than average, and it does so while offering them a choice of several health plans (and in this sense, it is like a purchasing cooperative). These people include individuals and employer groups that have above-average health risks, as well as other lower-income people.

Assuming the state absorbs the cost of any adverse selection, the approach provides a fair way of spreading the costs of covering high-risk people. The financing comes from state general revenues and is thus spread across the entire population. Assuming the tax system is fair, this represents perhaps the most equitable way to broadly spread the burden of subsidizing high-risk people. This contrasts with approaches that try to channel high-risk people into high-risk pools and then spread the subsidy costs across insurers, which means that self-insured groups (those exempted by ERISA from being subject to state insurance regulation) do not bear their "fair share" of the costs.

Disadvantages

The hurdles that would have to be overcome to make this approach ready for implementation are significant. Perhaps the most challenging task is to craft provisions to prevent the pool from becoming merely a high-risk pool. If the state absorbs the cost of adverse selection, there is a danger that the pool could be a "dumping ground" to which insurers and insurance agents relegate high-risk groups and individuals. Also of concern is possibility that large numbers of individuals will wait to get coverage until they know they need expensive medical care. Extreme adverse selection could greatly increase the level of the state subsidy needed to make coverage available at

affordable costs. The fact that eligibility is limited largely to lower-middle-income people should help to reduce the danger, but other protections would probably also be necessary. Examples could be having a short open enrollment period and having waiting periods for coverage of pre-existing conditions. Such provisions, however, make the system more complicated to administer.

A second reason to avoid excessive optimism about this approach is that experience shows that merely making coverage available will not ensure that target populations will take advantage of it. Experience with health purchasing cooperatives shows that it is difficult to attract customers, especially customers who have the option of going to more conventional sources to find average-priced coverage. Without being able to attract a number of these normal-risk individuals and groups, the dangers of adverse selection are exacerbated.

Cost and Impact on Uninsured

The cost and take-up rates estimates for this approach were calculated for several sets of assumptions regarding the extent to which the state would absorb the adverse selection costs and the extent to which it would go beyond that and also subsidize the cost of the normal-risk premium. Two of those alternative sets of assumptions are presented in Appendix E. The estimates assume reasonably comprehensive coverage, but less comprehensive than the state employees' plan.

Premium Assistance through S-CHIP For Available Employer Coverage

The Approach

Federal law permits states to establish a program to subsidize premium costs for the families of S-CHIP-eligible children to enroll the whole family in cost-effective employer-sponsored coverage when it is available to the parents. Employers would have to contribute a federally specified minimum portion of the premium. The state and the employee, based on family income, would share the cost of the remainder of the premium. Because the employer pays part of the bill for S-CHIP-eligible children, the state's cost to cover the children is likely to be lower than if they were enrolled in the "standard" state-based S-CHIP program. The savings would be used to subsidize the coverage for the parents of S-CHIP children.

The financing burden would be shared among the state, the federal government, businesses, and participating families. The federal government would match state funds at 65 percent, the same rate as for the regular S-CHIP program. Whether the state would pay more than it does now depends on many factors—the take-up rate, the proportion of premium that employers cover on average (since some would pay more than the minimum), the share of the premium required of families, average family income of participating families, and so forth.

When this option was first considered, it was put aside for two reasons: the federal requirements to implement the approach were onerous and very difficult to implement, and the experience in other states that had tried the approach produced low take-up rates. However, the federal government very recently issued new regulations that make this option much more attractive. The new waiver authority promulgated as the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative by the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) allows flexibility in development of the scope of benefits and the amount of beneficiary

cost-sharing (such as copayments and premiums). This flexibility makes this option more feasible. As a result, it is appropriate to include it among those that deserve further attention and development. However, because the new waiver authority was issued just prior to the completion of work leading to the writing of this report, there was not time to develop cost and impact estimates for this option.

Target Population

The target population for this option is employed parents who have children eligible for S-CHIP and who work for an employer that offers health coverage.

Advantages

A major advantage of this approach is that S-CHIP funds (with the federal match) can be used to cover parents of S-CHIP children without an increase in government funding. This is possible because the approach leverages employer funds that would otherwise not be used. Moreover, the approach can reinforce and expand employer-based coverage and help avoid crowd-out that could be a consequence of other programs that offer new subsidies to people that are eligible for employer-sponsored plans. The approach has the potential to reach a large number of people, since national survey data indicate that a significant portion of uninsured children and parents, particularly those with incomes between 133 percent and 250 percent of the federal poverty level, are eligible for employer-based coverage.

Children and parents would be covered under the same insurance plan with the same provider networks, thus making it more likely that the whole family would receive regular, properly coordinated care. Furthermore, if subsidies are provided to parents to enable them to afford the employee contribution, overall take-up rates might be higher; that is, some families reluctant to enroll their children in S-CHIP as a separate program (with possible connotations of "welfare") might more readily enroll in their employer's plan.

Disadvantages

There is the potential for crowd-out: some low-income families now paying for employer-based coverage might drop it, knowing that they are eligible for the same coverage on a subsidized basis; and employers could reduce their contribution, knowing that state subsidies would fill in for the cost employees would otherwise bear.

Implementing such a program is likely to be complicated, even though recent federal changes increase flexibility and reduce the difficulties involved in implementing the approach. But it is inherently administratively complex. It remains unclear whether, given the greater flexibility, the state could design and implement a program that would be more successful in attracting significant numbers of currently uninsured families than was the case the states that previously tried this approach.

We acknowledge that this approach addresses a specific target of the uninsured and does not necessarily speak to separate populations such as parents whose employers do not offer coverage or uninsured adults who do not have children eligible for S-CHIP, however we feel the inherent logic of public private partnering and the recent passage of HIFA sufficiently outweigh these disadvantages enough to warrant additional research.

Section 5. Consensus Building Strategies

Governance Structure

- **The Planning Grant Lead Agency**
  The Delaware Health Care Commission (DHCC) is an independent public body that reports directly to the Governor and the General Assembly. Commission membership is comprised of four (4) government officials and six (6) private citizens. The enabling legislation used by the General Assembly in 1990 to create the Commission specifically charged the entity with creating a pathway to basic affordable health care for all Delawareans. The Commission has undertaken this charge through the systematic, comprehensive analyses of Delaware's health care market place structure, financing, and delivery mechanisms.

- **Project Steering**
  The Commission served as a steering committee to this project and invited technical assistance from the Delaware Division of Social Services Medicaid Unit and the University of Delaware, the two principal data owners of the required information for this process. These key partners are leading authorities on the characteristics, demographics, and trends of Delaware's uninsured population. A representative from the Governor's office has also participated in this process. Over the course of the planning period, other key public and private stakeholders have been identified and their input sought on an ongoing basis. Personal office visits and special briefing meetings were conducted with a variety of key stakeholders at the onset of the planning process and on an ad hoc basis throughout the planning process. The purpose of these meetings was to explain the purpose of the planning process, identify other stakeholders who may benefit by knowledge and understanding of the planning process, and to extend open invitation to steering committee meetings. One such referral gained through these more personal meetings was to a group of health industry executives who meet informally on an ad hoc basis. We had the opportunity to convene that group twice during the planning process and utilized their collective experience and input as a focus group type of information gathering activity and, later in our process, as a reactionary panel to our findings and possible strategies for the future. This group is described further in the "Methods for Obtaining Input" section below.

- **Involvement of the Legislative Branch of Government**
  Individual meetings with the respective Chairman of each the House and Senate Health Committees were conducted throughout the planning process. These elected officials in turn apprised their colleagues of the process in a more personal manner. The entire General Assembly has received invitation to each of our Policy Forums and will be targeted for more specific discussion during our extended grant period.

Methods for Obtaining Input

- **Background**
  One of the first tasks completed by the steering committee was agreement to the overall process to be administered during the planning period. Discussion and decision making relevant to this process hinged upon four common beliefs:

a) Delaware has a great deal of existing data about the uninsured, but that data needs to be scrutinized and extrapolated for better understanding of incremental and targeted solutions.
b) A data driven decision that identifies a subpopulation(s) for whom to create policy/program design recommendations that will have the most significant impact in terms of covered lives is critical.
c) Stakeholders and opinion leaders pertinent to identified target populations must be included in the process for preliminary opinions, perspectives, and experiences relative to the populations' lack of health insurance.
d) These key constituencies represent information that is integral to discussing our overall health environment.

A preliminary list of key stakeholders was identified for the purpose of providing a project briefing, generating dialogue and getting input, and to answer stakeholders' questions about how they can best partner with our process. This original list of key stakeholders included the following: the Medical Society of Delaware, Hospitals, Chambers of Commerce, the Contractors Association, the Insurance Industry, Community Health Centers, Legislators, the Executive Branch, the UAW/Chrysler Community Health Initiative, and consumers. This original list was by no means considered to be exhaustive, but rather the starting point for disseminating information and getting feedback about additional stakeholders to include in the process. As discussed above, members of the workgroup conducted individual meetings with these above listed stakeholders. It was quickly evident that a larger method of obtaining the simultaneous input from these stakeholders was required in order that our process not be hindered by individual constituency opinions but rather had the benefit of knowing how these constituency opinions were affected by one another. The workgroup adopted a strategy from a model known as the "Assembly Method" of community input as an enhanced strategy of building constituency as opposed to conducting traditional public hearings at the end of the planning period. Our process convened opinion leaders to frame the issue and generate input, and in intervals reconvened those stakeholders to respond to findings, possible strategies, and possible impacts. A final product is developed through this collaborative process. Using this method, the steering committee oversaw the completion of information gathering and disseminating activities utilizing a variety of tools:

- **Policy Forums**
  Policy conferences were scheduled for February 2001 to frame the issue and overview the intended process, June 2001 to share research findings and generate input on possible strategies, and September 2001 to communicate a shared vision of a possible path forward. The objectives of each forum are included in Appendix G. Due to national events occurring in September 2001, we were unable to complete the third policy conference.

- **Focus Groups of employers and individuals**
  Four sessions were conducted (two of employers and two of employees) in each the northern and southern area of our state. Focus groups were a planned strategy for gaining the input of the small business community (less than 50 employees) who do not or in the recent past did not offer insurance coverage. The input of individuals employed by small firms who do not offer

health insurance coverage was equally important to our process. Focus group results are provided as Appendix C.

- **Employer Survey**
  At the onset of the planning activity, it was determined that more information is needed from Delaware employers relative to what types of insurance products they offer, why or why not, and what the necessary incentives may be in order for them to offer insurance coverage if they now do not. The University of Delaware's Center for Applied Demography and Survey Research was contracted to complete this activity. As a prerequisite to finalizing the survey instrument itself, the University completed a field-testing of a possible survey instrument [the 2000 Small Employer Health Benefits Survey (SEBHS)] and used the opportunity to create preliminary discussion of issues affecting small employers. Representatives from five (5) statewide small businesses were convened to offer perspective on relevant issues that needed to be addressed in the instrument. Feedback from the field-testing session is included in Appendix H.

- **Sounding Board Meetings**
  Two meetings were conducted with leadership from the state's medical community including providers and payers. Approximately 16 attendees from insurance companies, the State's Medicaid program, the Medical Society of Delaware, hospitals, the Delaware Healthcare Association, Government Relations, attended each of two meetings. This group of executives meets randomly and informally to discuss issues of shared concern. Feedback from each of the two meetings was extraordinarily insightful and is included in Appendix I.

Other Information Dissemination and Gathering Activities

- **Website Development**
  As a component of the state planning process, The University of Delaware created and continues to host a website www.delawareuninsured.org. The website contains a wide variety of reports on the uninsured, including the annual demographic update. Also featured are a calendar, presentations from meetings, and an interactive area for threaded discussion. The website is promoted as an additional and ongoing means of gathering public input and as a forum for sharing information.

- **Community Representation**
  An overview and update of the State Planning process is included as a standing agenda item on a number of community based organizations monthly board of directors meetings. Examples of such venues include the Central and Southern Delaware Community Health Partnerships, the Delmarva Health Initiative, the Community Healthcare Access Program, the Delaware Foundation for Medical Services, and the Delaware Perinatal Board.

- **Travel**
  The workgroup hosted a visit from representatives of a coverage program based in Michigan. Members of the workgroup had heard presentations from this project within the scope of other activities, but recognized the strategy being utilized as one that warrants further development in Delaware (the 1/3 share plan). Site visits will be hosted or conducted to other states as our options are refined and effective demonstrations of such models are identified.

Current Policy Environment
Following is a brief description of the political environment and contextual framework in which planning activities have been completed.

There is no agency or organization in the state better suited than the Delaware Health Care Commission (DHCC) to have lead a planning process requiring critical input from government, public and private sectors. The enabling legislation used by the Delaware General Assembly in 1990 to create the DHCC specifically charged the entity with creating a pathway to basic affordable health care for all Delawareans. Systematic, comprehensive analyses of Delaware's health care market place structure, financing, and delivery mechanisms have been required to render any possible comprehensive and effective solution(s) to the problem of the uninsured. The DHCC has for nearly a decade tracked and investigated the issue of the uninsured through the compilation of research and the administration of pilot initiatives.

Interest in the State Planning Grant program was most strongly linked to the harmony between SPG purpose and legislated purpose of the DHCC. In addition, the DHCC is in a unique position to provide input to potential long term financing mechanisms such as the Delaware Health Fund Advisory Committee. The Commission is charged with providing research, guidance, and advice to the Committee. The Delaware Health Fund was created as the financial vehicle for the investment of Delaware proceeds reached under the Master Settlement Agreement between the nation's attorney generals and the tobacco industry. The Advisory Committee oversees the Fund. Success indicators for the expenditure of these proceeds have been established based on public input and include *"Strengthening the infrastructure, and expanding access to health insurance and services for all Delawareans."*

It is important to note that the Commission attends to the broader responsibility of overseeing the "Uninsured Action Plan" (UAP). The UAP has two components: planning and policy direction, and implementation of direct service delivery initiatives. As a recipient of proceeds of the state's Tobacco settlement, the Commission made commitment to pursue the thoughtful development of strategies to address the problem of the uninsured in Delaware. These Tobacco Settlement funds provided significant leverage to the Commission on two federal Health Services and Resources Administration grant awards: the State Planning Grant (SPG) and the Community Access Program (CAP). Receipt of federal funding under each of these programs (SPG and CAP) has enabled more thorough completion of activities, and perhaps more importantly the opportunity to safeguard the Tobacco Settlement funding for use in implementing strategies on which consensus has been reached as a result of the planning process.

Since the time of initiating state planning activities, Delaware has experienced a change in administration. A number of changes took place at Cabinet-secretary positions within the first months of Governor Ruth Ann Minner's term with many of the new appointees continuing to learn Delaware's health environment. Parallel to these changes in administration, Delaware's economy has turned downward. The State is operating within an environment of extreme fiscal constraint at present. The consensus building process has provided repeated indication of the need for economic feasibility of implementing any strategy. The fiscal environment does not at this time provide such feasibility for implementing any option, but does provide the stimulus to continue

research into such tangential items as provider capacity, safety net capacity, and alternative financing mechanisms in order that our ultimate implementation strategy stands poised to address political, fiscal, and philosophical viability tests.

Section 6. Lessons Learned and Recommendations to States

Data Collection Activities

Most Valuable:
Key stakeholders have provided supportive feedback for the process of using a series of policy conferences and have articulate their appreciation in having the issue concisely framed, being given the subsequent opportunity for dynamic input, and many had anticipated the final conference to learn of possible solutions. Use of the assembly method of input gathering was an effective process that we will utilize again for a variety of issues.

The employer survey process too, was effective in terms of data gathered and response rate. In addition to basic survey questions, we enabled respondents to provide open feedback and to identify themselves if interested in further discussion. Interestingly, respondents did identify themselves and have since provided ongoing input.

Perhaps the most striking informal data collection came without cost and was the result of personal briefing meetings with targeted stakeholders. Delaware's small size and close-knit relationships provide a particularly receptive environment for this type of activity.

Would do Differently:
The focus group recruitment process was inordinately difficult and created a sense of frustration that was not counterbalanced by any unique insight gained through the focus groups. We had the support of the State Chamber and many local Chambers as we entered the recruitment process who had provided listing of approximately 800 businesses that met our focus group participant criteria. Not withstanding, we had to cancel the first scheduled series of focus groups due to limited participants and had to offer financial incentives in order to get a minimum number of participants when we did complete the sessions. The most recurring refrain we heard from business owners was that there was no amount of financial incentive that would encourage their sacrifice of work hours. We inherently suspect that vendor contracted recruitment could have played a role in this result, but recognize as well that it could speak more broadly to this topic not being of priority to employers.

Planned but not Completed:
A possible means of gathering more information about uninsured individuals directly is through having direct communication at a time that is conducive for such conversation. One such time is upon the individual's denial from a public insurance program. We know that these low-income individuals were motivated to be interested in health insurance coverage. The Delaware Division of Social Services could report this information through modification of its client information system. This modification has both procedural (gaining release of information consent) and financial implications (system enhancements). New administration and budgetary considerations lessened the practicality of this activity during this planning period.

Additional Data Needs:
The following data collection activities were identified as critical during the course of our planning process and will be completed during the extended grant period.

- ***Safety Net Capacity Analysis***. We need to understand the financial viability and capacity of safety net providers, specifically community-based health centers, to absorb any more patients, particularly at rates less than cost of services. There is a great deal of public interest in utilizing the network of safety net providers that has integrated through HRSA's Community Access Program as the foundation for some type of program that would either provide limited benefits to patients or in some manner directly subsidize the service providers.
- ***Repeat survey data (CPS, BRFSS, and CAHPS) on a larger sample size.*** A repeat survey on a larger sample size would allow comparison to previous trends.
- ***Input from elected officials***. Time prohibited the collection of this specific input but it is critical for obvious reasons. All the members of the General Assembly were invited to the series of policy conferences, but a separate forum for dialogue has not been conducted yet.
- ***Improved understanding of the total cost of health care in Delaware and the financial implications of cost shifting***, and
- ***Legislation will be required to amend the law that currently authorizes the reporting of hospital discharge data to include outpatient data***. We need outpatient data to expand the scope of our knowledge about ambulatory service utilization and create a capability to monitor problems.

Coordination of Health Care Programs

The planning process has not resulted in operational change to our public health insurance programs (Medicaid and SCHIP), however the planning process has provided a better understanding of program design and function and has clearly underscored the importance of effective outreach. Towards that end, a great deal of program design attention within the HRSA funded Delaware Community Healthcare Access Program (CHAP) has been directed towards simplification of the application and enrollment process and outreach at logical statewide locations.

The CHAP is a standardized screening and eligibility system that links patients with public insurance products for which they may be eligible, and in the absence of eligibility provides linkage to a no-cost or low-cost medical home. The premises that CHAP has been built on are that uninsured patients with a regular source of primary care are healthier and more appropriate users of the health system thereby less costly to the overall system. Implementation activities under the CHAP have run on a parallel track to state planning activities. This parallel relationship has been doubly advantageous in that CHAP program design and eligibility requirements were developed based upon knowledge gleaned through the planning process, and continued planning activities have benefited from the experiential data gathered through CHAP.

Key Lessons Learned from Health Plan and Employer Community

- There are few large health plans in Delaware. As a result there is little competition. Health plans were not receptive to the idea of a "state negotiated Health plan" that would utilize the leveraging capability of the state to gather bids on a separate risk pool of individuals. Additionally, health plans communicated a need to not structure any plan in such a way that it would appear to be "state mandated" as this would interfere with providers willingness to participate.

- When speaking of possible program design elements, a great deal of concern was expressed from the business community about participation eligibility. The idea of making a new public private partnership program (e.g., a 1/3 share plan) available only to businesses who do not offer coverage is potentially offensive to small businesses who have historically offered coverage because they felt it the "right thing to do", even though that decision may have adversely affected their bottom line.

- Business owners routinely cited the need for more information and accurate information about the tax treatment of providing employee insurance benefits, the actual costs of providing benefits, and the availability of products that can be compared against one another for determining value. Basic information such as policy options, role of brokers, and fair pricing was consistently identified as an outstanding need.

Key Recommendations to Other States Entering a Planning Process

- One year is not enough time. Some activities require sequential versus concurrent processing. Data gathering activities are lengthy. Key constituencies often seek answer to data questions during the input gathering process. A level of inefficiency is created by not having immediate quantifiable information to address key concerns.

- The universe of key stakeholders must be inventoried at the onset of the planning process and a "plan" constructed for how to engage that variety of stakeholders in meaningful conversation that is valuable and manageable. Conceptually developing ideas that will enable swift and consistent address to the question of "what's in it for me?" is critical for managing dynamic relationships and forming alliances.

- The involvement of the safety net (or the backbone of ambulatory clinical care to the uninsured and underinsured) is critical to program success for several reasons. First and foremost, as plans are developed that will potentially provide reimbursement for nonpaying patients it is critical to have the input and impact assessment from providers who treat the lion's share of these individuals. Secondly, but not less importantly, it is critical to recognize that there will always be individuals whom will not participate in insurance coverage despite their eligibility and the products accessibility. These individuals will continue to strain the financial capacity of the safety net.

- Effective and comprehensive outreach programs are necessary to reach individuals that are eligible for public insurance products yet, for whatever reason, remain unenrolled. In Delaware we know that there are several variables that contribute to the ranks of the eligible but unenrolled- first and foremost being the perceived stigma of government assistance programs. We further know that we lose individuals during the eligibility redetermination process, at which time individuals must reproduce income verification documentation. Without such documentation, coverage lapses. Lastly, we recognize that for some individuals the concept of insurance has little to no value given their daily economic reality. Approximately 30% of Delaware's uninsured fall within income brackets that would suggest their eligibility for a public program.

Section 7. Recommendations to the Federal Government

For Delaware, the State Planning Grant program has provided the means by which to analytically determine that an incremental and evolutionary approach towards universal health coverage is most feasible for Delawareans. Through our process we have identified a number of possible solutions and strategies regarded as those most probable of having the most significant impact in terms of covered lives as well as simultaneously meeting political and financial viability tests. Our research has rendered an array of options that are not necessarily treated equally in terms of priority, but rather warrant the determination of the best manner of staging short and long-term strategies. We have come to believe that there will be no circumstance, short of national health reform, that renders coverage to 100% of our uninsured population. We know that at least 50% of our uninsured individuals have been so for over 13 months. Our "best" strategy may be able to successfully reach approximately half of those who have been chronically and longstandingly uninsured. All of the options that we have explored target individuals with a maximum income up to 300% of the federal poverty level (the median income level). Approximately 30% of Delaware's uninsured are above the median income level. Our strategy will at best be cobbled. The US health system generally speaking is fraught with social, economic, and ideological complexities. The federal government and states need to partner to better understand the very construct of the system and evaluate the question as to whether continuing to build upon it inherently makes any more sense than thinking to restructuring it in whole.

Most Americans, and most Delawareans, access health insurance coverage through their place of employment. Rising costs make it increasingly difficult for employers, particularly small employers, to offer this benefit. As laboratories of progress, States have tried to make strides in designing programs that enable their citizen's access to affordable, appropriate health care. The federal government's flexibility for allowing innovation has to date posed significant administrative hurdles to States. Delaware welcomes the flexibility offered by the federal Health Insurance Flexibility and Accountability Demonstration (HIFA). The federal government must be a partner in order to effectively address the problem of expanding coverage. As a result of the timely passage of HIFA, we were able to return one of our earlier disregarded options to the "drawing board". The concept of employer buy-in to public products is intuitively appealing as well as recognized by key Delaware stakeholders as a logical approach to expansion. The federally imposed complexities of this type of strategy, in combination with the slow start up and limited impact of this type of approach in other states (e.g. Wisconsin) had resulted in our decision that the option, ***prior to HIFA***, lacked the warrant of further exploration. In keeping with the spirit of HIFA, it is critical that the federal government recognize the important trade-offs between coverage and cost. Strict federal rules on benefit design, cost-sharing limitations, and cost effectiveness tests require that states make choices between offering some basic services to some segments of the uninsured population, or allowing them to continue with no coverage at all. While such federal flexibilities are not the "solution", they are crucial as States continue to incrementally address various populations of the uninsured.

In regard to specific and meaningful federal incentives that could evoke expansion coverage activities within States, our planning process has rendered several suggestions. Foremost is that with a slowing economy States and business will have an increasingly difficult time funding major expansion initiatives. If we are to expand beyond our current system of public and private

coverage, it will be necessary for the federal government to become financial partners with States. With the economy as it is, we will have to place a great deal of priority upon maintaining the current public system. Most of the nation's uninsured work, many for small businesses for whom the task of purchasing health insurance is difficult and expensive. States for example have limited ability to offer tax incentives for small businesses to purchase affordable health insurance. The federal government, however, could offer meaningful incentives.

We commend the relationship building resources that the federal government has provided through the Department of Health and Human Services, Health Resources and Services Administration (HRSA) such as the State Planning Grant program and the Community Access Program. It should be noted however that a one-year State Planning period is insufficient to address the intricacies and complexities of the US health system. Future grants of this kind (planning) should allow more time for grantees to thoroughly analyze and develop options. Through each of these HRSA sponsored grant activities, the provision of technical assistance has been phenomenal. Unfortunately, the time allotment for producing agreed upon grant deliverables is such that we often feel unable to utilize those resources. Nonetheless, these grant programs have been invaluable and we are deeply appreciative of the solid relationships that we have been able to establish with our federal program officers.

The Community Access Program (CAP) has enabled over 100 nationwide communities to create innovative solutions to the issue of accessing culturally appropriate, community-based care. A strong and viable safety net is a critical component to reaching some segments of the population with primary and preventive services. We recommend continued federal support of federally qualified health centers and are pleased with the Presidential initiative to significantly expand access points. As a CAP grantee serving a statewide community, we have had the extreme benefit of coordinating those direct service delivery initiatives findings with our planning process.

When considering the question of what, if any, research might be helpful for the federal government (or other organizations) to conduct for purposes of identifying the uninsured or developing coverage expansion programs, we can think back only to some of the tangential questions that occurred during our process; take up rates versus crowd out design features, the impact of insurance accessibility on health status, and the any difference in effect between individual insurance coverage v. subsidy for direct service delivery. These were questions that answers to which we understood not to be readily available, nor for which we could expend the time for research.

APPENDIX A:

DELAWAREANS WITHOUT HEALTH INSURANCE 2000 REPORT

Delawareans Without Health Insurance
2000

prepared for
the Delaware Health Care Commission

by

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Introduction

The Delaware Health Care Commission has, since its inception, been concerned about access to health care for all Delawareans. While that is not its only focus, since the Commission's mandate is broad, improving access to health care is a primary goal. Access to health care has several dimensions. One of those dimensions is covered in this report, and that is health insurance coverage. Those with health insurance typically enjoy greater access to health care providers than do those who are without it.

Persons who do not have health insurance are still likely to require medical care at some point in time. When they do require such services, their condition may be significantly worse than had it been detected and addressed at an earlier stage. In addition, the uninsured will tend to use one of the most expensive providers, the emergency room. Ultimately, providers must cover all of their costs. Services delivered to the insured and the uninsured alike, figure into that cost. As a result, some of the cost of services provided to the uninsured is shifted to the insured population. This raises the overall cost of fringe benefits to employers.

To better understand the nature of the uninsured population, the Delaware Health Care Commission has been monitoring its size and structure for a number of years. This report is a significant update and offers both new information and analysis. It adds information for the years 1998 and 2000 to the database. In addition, much of the information is now reported as three-year averages in order to add stability to the estimates. Finally, adjustments have been made to some of the tables to reflect recently reported 2000 Census data. This will make figures that report counts rather than percentages inconsistent with prior reports.

The report has three major sections. In the first section, the current status of the uninsured in Delaware and the region is discussed. A time series, beginning in 1982 and ending in 2000 is used to show any trends. The second section focuses on the labor market in Delaware and existing and future trends that might affect employer provided health coverage. The third section contains information on health insurance coverage for a variety of demographic variables. The implications of current demographic trends are also considered in this section.

The Uninsured

Background

Two primary sources of data are available for measuring access to health insurance in Delaware. The first source is the March Current Population Survey (CPS), conducted annually by the U.S. Bureau of Census. The second source is the Behavioral Risk Factor Surveillance System, conducted monthly for the U.S. Centers for Disease Control and Prevention by the Center for Applied Demography and Survey Research at the University of Delaware, through the Delaware Division of Public Health. Both sources are valuable in their own right, but each has associated advantages and disadvantages.

The CPS is conducted monthly throughout the nation and is designed to measure the unemployment rate and other employment related statistics for the 50 states and the nation. More than 64,000 households are included in the sample and data is gathered on approximately 131,800 persons in those households. Each month, the basic employment information is gathered along with optional information that changes from month to month. The March CPS is usually referred to as the annual demographic file, since it captures a broad array of demographic information along with basic employment data. Part of that demographic information concerns health insurance coverage.

In Delaware, the CPS involves about 700 households monthly, usually containing more than 1,400 persons. This sample size is sufficient for producing statewide estimates on a wide variety of demographic indicators. When measuring the percentage of the population without health insurance, for example, the accuracy is approximately +/- 1.7%. This year for the first time, three-year averages can be reported at the county level.

The health insurance questions were added to the CPS in 1982. There were modifications to the questions in 1989 and again in 1995. However, a consistent data series can be constructed in spite of the changes. One aspect of the health insurance questions, time frame, is important to understand, since it differs between the two primary sources of data. The questions on the CPS are asked with reference to the previous year. Thus, in March 2000, respondents were asked about health insurance coverage in 1999. However, there is considerable evidence to suggest that the responses given are highly correlated with their current health insurance status or at least to

the current quarter. The U.S. Bureau of Census conducted significant parallel testing between the Survey of Income and Program Participation (SIPP) and the Current Population Survey. The SIPP sample of households is part of a panel that is re-interviewed quarterly for more than two years. Thus, the survey is able to more accurately follow the respondent's health insurance status over time. The comparisons of estimates of health insurance coverage obtained from the CPS show a strong relationship between the SIPP responses and the CPS responses at the time the questions were asked. Thus, for purposes of this report, the year referenced in the tables and text always refers to the year in which the question was asked.

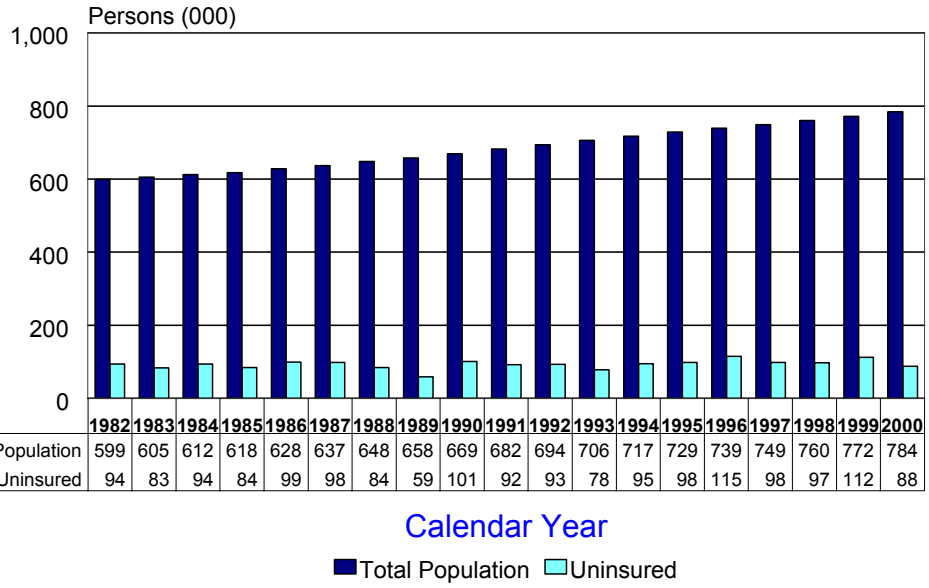
The second source of health insurance information is the Behavioral Risk Factor Surveillance System (BRFSS). The survey has been carried out by the Center for Applied Demography and Survey Research since 1990. The sample consists of residents of the state who are 18 years old or older. Each month approximately 300 households are contacted statewide and then an adult respondent is randomly chosen from within each household to be interviewed. The survey is wide-ranging. Among the questions asked are whether the person being interviewed currently has health coverage. If they are not covered, they are asked how much time has elapsed since they were covered. The limitation of BRFSS is that it only represents adults. However, the sample size is sufficient to obtain county level estimates that are more accurate than those that can now be obtained from the CPS. Together the BRFSS and the CPS provide a powerful set of data for understanding the health insurance problems in Delaware today.

In the balance of this section, the current estimates of the uninsured will be presented. In addition, time series information will be used to show trends contained within those estimates. Finally, county level estimates will be provided along with a comparison of Delaware with the larger region.

The Uninsured 1982-2000

The point estimates for the number of persons without health insurance from 1982 to 2000 are shown in Figure 1-1 below. The term "point estimate" is used here to describe the results obtained from the CPS for a single year. There are several general observations that can be made about the information contained in this figure. First, the number of persons without

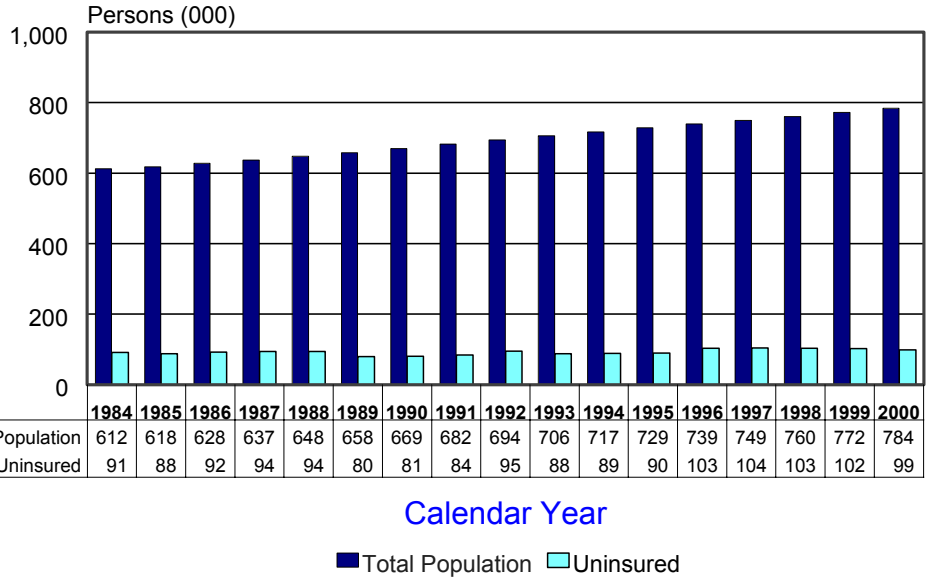
Figure 1-1
Estimated Persons without Health Insurance
in the State of Delaware



	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total Population	599	605	612	618	628	637	648	658	669	682	694	706	717	729	739	749	760	772	784
Uninsured	94	83	94	84	99	98	84	59	101	92	93	78	95	98	115	98	97	112	88

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1982-2000

Figure 1-2
Estimated Persons without Health Insurance
in the State of Delaware (3 year average)



	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total Population	612	618	628	637	648	658	669	682	694	706	717	729	739	749	760	772	784
Uninsured	91	88	92	94	94	80	81	84	95	88	89	90	103	104	103	102	99

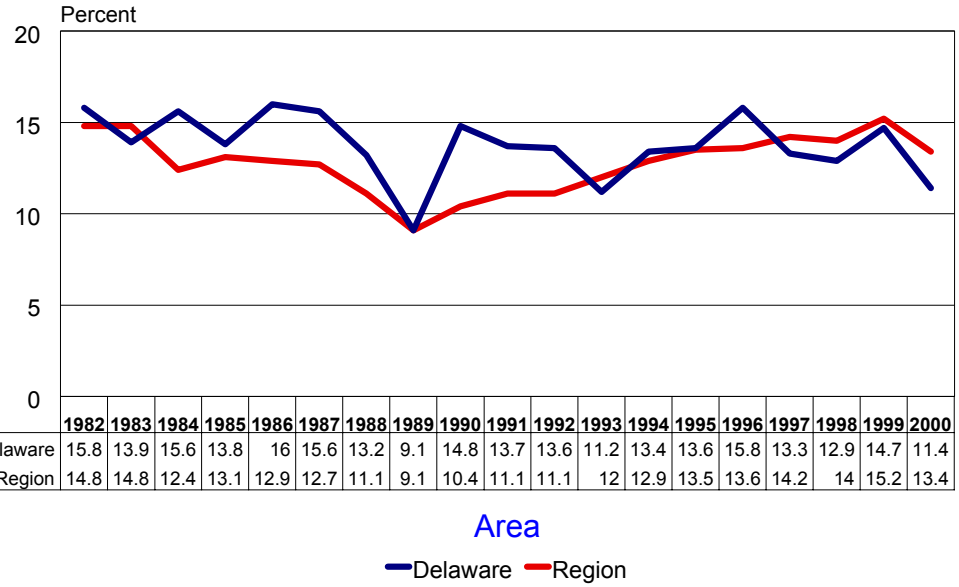
Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1982-2000

health insurance in 2000 (88,000) dropped substantially during the past year. Last year's estimate could have been the result of random variation. However, this year's estimate includes the full impact of the CHIP program for the first time. Both sources may have contributed to this result. This also includes the 2000 population count and that is 23,000 larger than previously estimated.

Second, while the number of uninsured has remained reasonably stable, the population of Delaware has increased by more than 185,000 since 1982. Had the number of uninsured kept pace with population growth, there would have been more than 35,000 additional persons without health insurance in 2000 based on the one-year estimate. Clearly, there are other factors operating that impact the number of uninsured apart from population growth.

Figure 1-2 shows the same information as a three-year moving average. This tends to remove some of the year-to-year fluctuations that are due to random variation associated with sample surveys. The number of uninsured varies between 80,000 and 104,000 over the entire period, which is a relatively small range given that the standard error is about 13,000. The sudden increase in the 1996 estimate appears to have been a statistical artifact that was not confirmed in either 1997 or 1998. A similar pattern occurred in 1999-2000. The 3-year average tends to moderate those movements.

Figure 1-3
Percent of Persons without Health Insurance
for Delaware and the Region



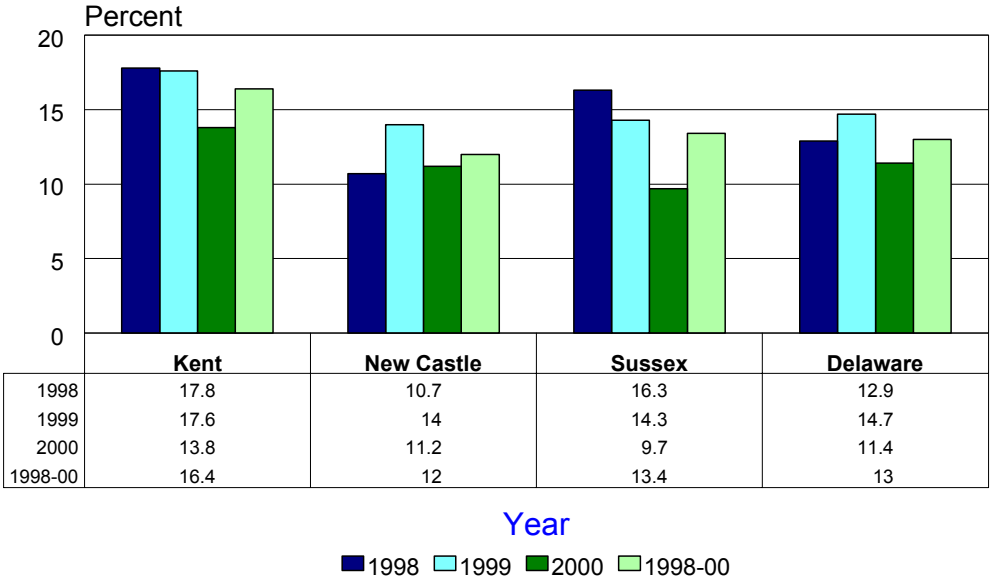
	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Delaware	15.8	13.9	15.6	13.8	16	15.6	13.2	9.1	14.8	13.7	13.6	11.2	13.4	13.6	15.8	13.3	12.9	14.7	11.4
Region	14.8	14.8	12.4	13.1	12.9	12.7	11.1	9.1	10.4	11.1	11.1	12	12.9	13.5	13.6	14.2	14	15.2	13.4

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1982-2000

The proportion of the population without health insurance, shown in Figure 1-3 above, has also shown distinct improvement since the recent peak in 1996. The rate has fallen over the years from about 15% in the 1982-1987 period to approximately 13.0% in the late-1990s. Some of this is undoubtedly due to legislative and policy initiatives, but at least some of the shift may be attributed to favorable demographics. In either case, Delaware is better off.

Also found in Figure 1-3 are comparative rates for the region which includes Maryland, Pennsylvania, New Jersey, and New York. From 1982 through 1992 Delaware's percentage of uninsured tended to be about 2% higher than that calculated for the entire region. However, as the graph shows, the percentage in the region began to rise after 1989 and has been flat or higher in most years. Delaware's rates, although more variable, tended to fall during the same period. At least part of this has to do with Delaware's economy, a job creation machine that was even able to absorb the impact of major job cuts by some of the state's larger employers.

Figure 1-4
Percent of Persons without Health Insurance in Delaware
By County



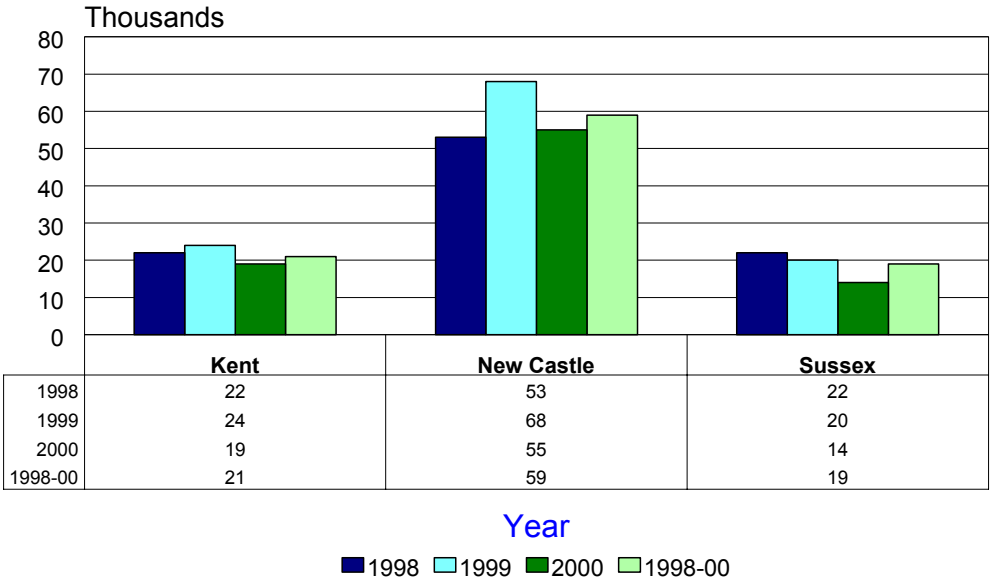
	Kent	New Castle	Sussex	Delaware
1998	17.8	10.7	16.3	12.9
1999	17.6	14	14.3	14.7
2000	13.8	11.2	9.7	11.4
1998-00	16.4	12	13.4	13

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1998-2000

Since 1996, the Census Bureau has provided county level identifiers on the CPS data. The sample sizes are sufficient to produce some rudimentary estimates at the county level. Since the sample sizes are small in Kent and Sussex counties, more random variation can be expected. The percentage of uninsured in each county is found in Figure 1-4, above. Both the single year

estimates and the three-year averages show significant differences between the county rates. Residents of New Castle County enjoy the lowest rate consistently during the three-year period. Kent County is highest, with the percentage of uninsured reaching more than almost 16% for the 1998-2000 period. Kent County residents are almost 37% more likely to be without insurance than those in New Castle County.

Figure 1-5
Persons without Health Insurance in Delaware
by County



	Kent	New Castle	Sussex
1998	22	53	22
1999	24	68	20
2000	19	55	14
1998-00	21	59	19

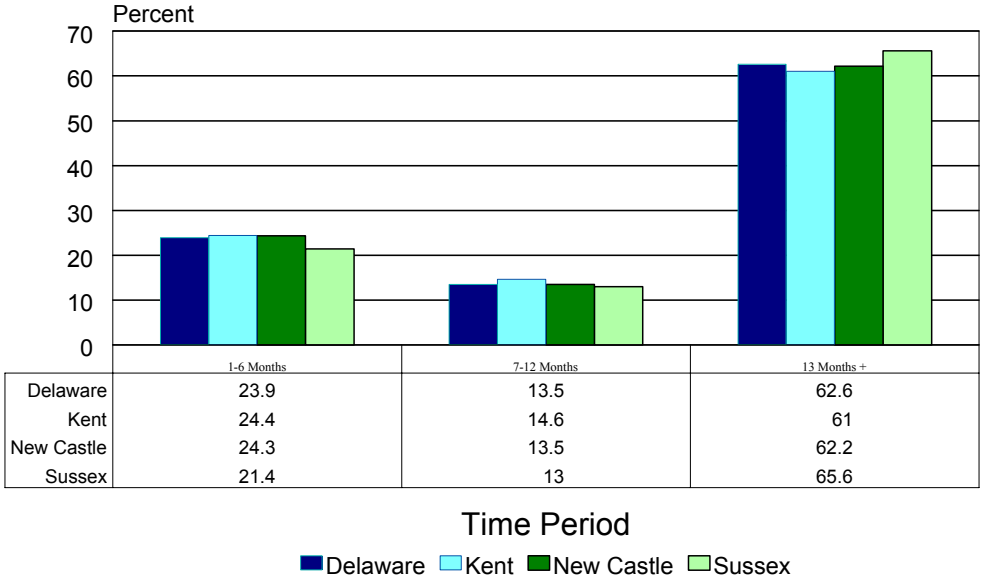
Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1998-2000

The estimates of uninsured persons by county are provided in Figure 1-5, above. New Castle County residents are the most numerous even though the rate is significantly lower. Almost 60% of the uninsured reside in New Castle County. The distribution is also reasonably stable over the three-year period with occasional exceptions.

There are several interesting questions that can be addressed by the Behavioral Risk Factor Surveillance System, information particularly about those who are without health insurance. Those respondents were asked, "About how long has it been since you had health coverage?" Their answers are displayed in Figure 1-6, below. The data is reported as a three year average since there is a great deal of variability in the responses given the sample size is constrained to the number of persons currently without health insurance. Even with that constraint, the results are quite consistent. About 24% of Delawareans who are uninsured are

without insurance for from one to six months. A little more than 13% of the uninsured respondents report being without insurance for up to a year. These data suggest that the majority (almost 63%) of Delaware's uninsured adults have remained uninsured for a significant amount of time. The longer the period an individual is without coverage, the higher the likelihood that they will develop a need for medical services.

Figure 1-6
Length of Time without Health Insurance in Delaware by County



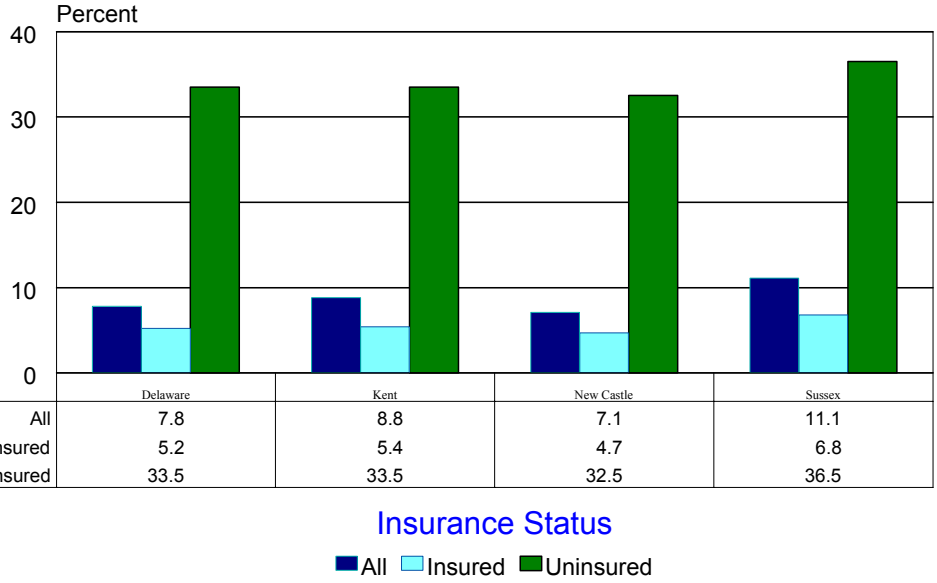
	1-6 Months	7-12 Months	13 Months +
Delaware	23.9	13.5	62.6
Kent	24.4	14.6	61
New Castle	24.3	13.5	62.2
Sussex	21.4	13	65.6

Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Health and Social Services, 1998-2000 Behavioral Risk Factor Survey

If 63% of adult Delawareans remain uninsured for one year or more, there is a high likelihood that they may need medical services of some kind. In addition, it is also likely that routine preventative measures may be overlooked. The BRFSS gives some insight to this issue in a question addressed to all respondents. They were asked if they had needed to see a doctor in the past 12 months but could not because of the cost. Their answers are tabulated in Figure 1-7, below.

About 5% of the people who currently had health insurance answered affirmatively to that question. In contrast, those currently uninsured were seven times more likely to say that they had to forego a visit with a doctor. Those same results apply equally well across the three counties.

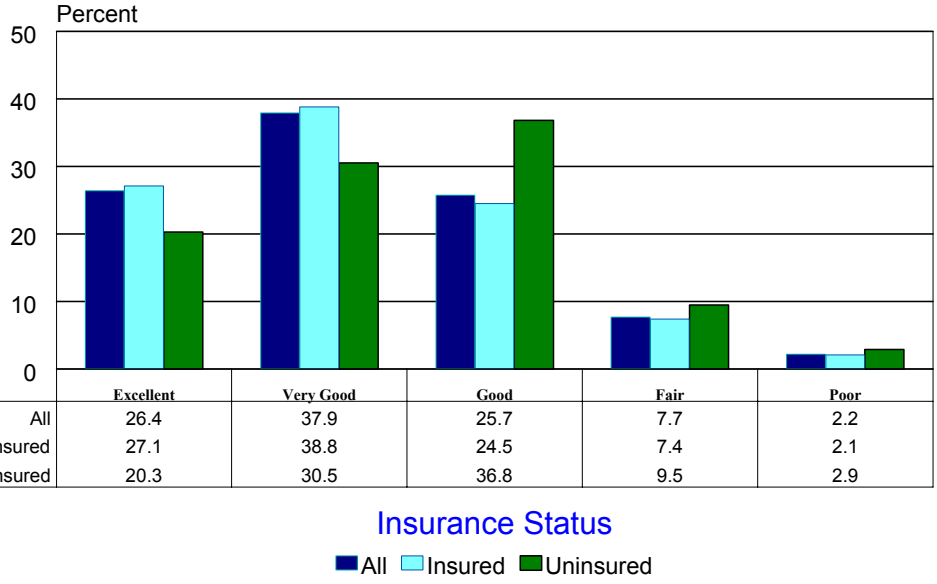
Figure 1-7
Needed a Doctor but too Costly
by Insurance Status and County



	Delaware	Kent	New Castle	Sussex
All	7.8	8.8	7.1	11.1
Insured	5.2	5.4	4.7	6.8
Uninsured	33.5	33.5	32.5	36.5

Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Health and Social Services, 1998-2000 Behavioral Risk Factor Survey

Figure 1-8
Health Status
by Insurance Status

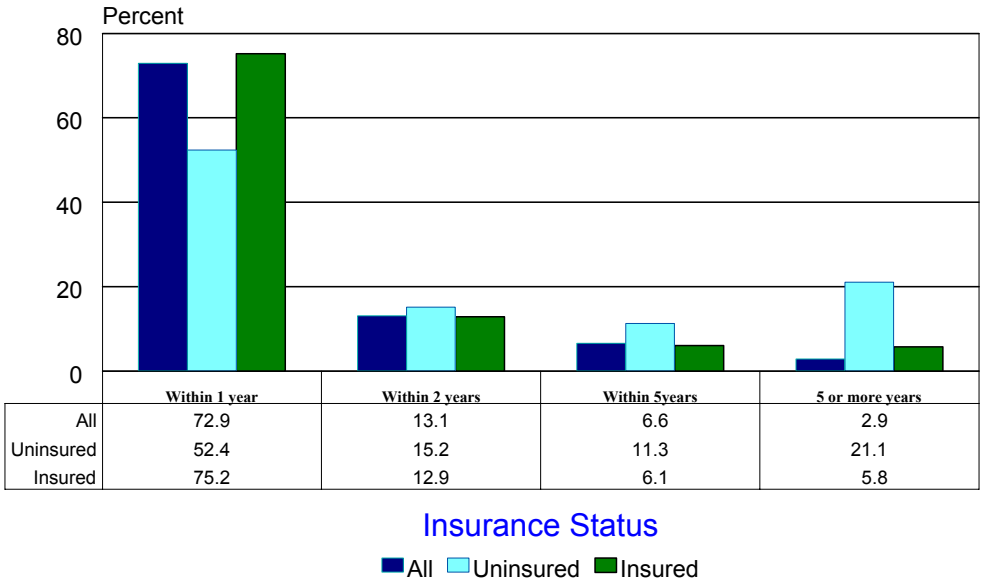


	Excellent	Very Good	Good	Fair	Poor
All	26.4	37.9	25.7	7.7	2.2
Insured	27.1	38.8	24.5	7.4	2.1
Uninsured	20.3	30.5	36.8	9.5	2.9

Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Health and Social Services, 1998-2000 Behavioral Risk Factor Survey

There is also reason to be concerned about the uninsured and their need for medical coverage. They may need a doctor more often if their health status is less positive than those who are insured. Evidence to this possibility is found in Figure 1-8 above, where the uninsured tend to be less optimistic about their health status.

Figure 1-9
Time Since Last Routine Checkup
by Insurance Status



	Within 1 year	Within 2 years	Within 5years	5 or more years
All	72.9	13.1	6.6	2.9
Uninsured	52.4	15.2	11.3	21.1
Insured	75.2	12.9	6.1	5.8

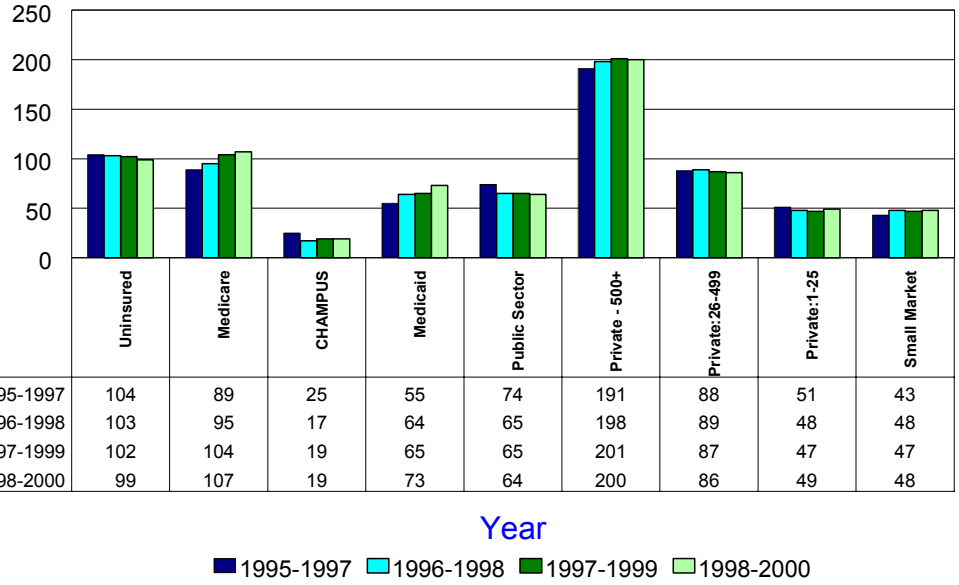
Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Health and Social Services, 1998-2000 Behavioral Risk Factor Survey

One other often mentioned feature of the uninsured is that problems are detected late and then treatment is more difficult. This position is supported by the data displayed in Figure 1-9 above. A person who reports being without insurance during the last year is more likely not to have had a routine checkup.

Finally, it is useful to understand something about how people obtain their health coverage. This can be particularly important in determining the amount of influence government policy can have on Delaware's population. Figure 1-10 below shows that Delawareans get their health insurance in many different ways. Excluding the 99,000 uninsured, about 199,000 people receive their health insurance through one of three government programs, Medicare, Medicaid, or one of several military sources (CHAMPUS). The public sector at all levels insures some 64,000 residents. Within the private sector there are two distinct groups. The large employers (more than 500 employees) are largely self-insured and don't utilize the insurance market in a conventional

way. These account for the largest single group of residents numbering more than 200,000. The balance, some 183,000 obtain their insurance through smaller employers who purchase various group plans in the insurance market or obtain insurance as individuals.

Figure 1-10
Number of Persons in Delaware
by Source of Insurance



	Uninsured	Medicare	CHAMPUS	Medicaid	Public Sector	Private - 500+	Private:26-499	Private:1-25	Small Market
1995-1997	104	89	25	55	74	191	88	51	43
1996-1998	103	95	17	64	65	198	89	48	48
1997-1999	102	104	19	65	65	201	87	47	47
1998-2000	99	107	19	73	64	200	86	49	48

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census Current Population Survey, March 1995-2000

One interesting feature of this information, not found in Figure 1-10, is that many people report having multiple sources of health insurance over the year. For example in 2000, 13.2% of the population reported receiving Medicare, but only 4.6% say that Medicare was the only source of insurance that they had during the year. Similarly, 13% reported Medicaid as their source of coverage, but only 4.2% said that it was their only means of coverage. These two situations probably represent two different dynamics. Medicare recipients are quite often carrying additional insurance to cover any medical services not handled by that program. Medicaid recipients, on the other hand, seem to be more likely to move from some type of group coverage to Medicaid and back again as their life situation changes.

In conclusion, it should be noted that, while at any point there are approximately 11.4% of Delawareans uninsured, the proportion that are uninsured at some point during the year is closer to 18% based on national statistics. The same statistic derived from the Survey of Income and Program Participation, points to a median time without coverage of 7.1 months. This rate is

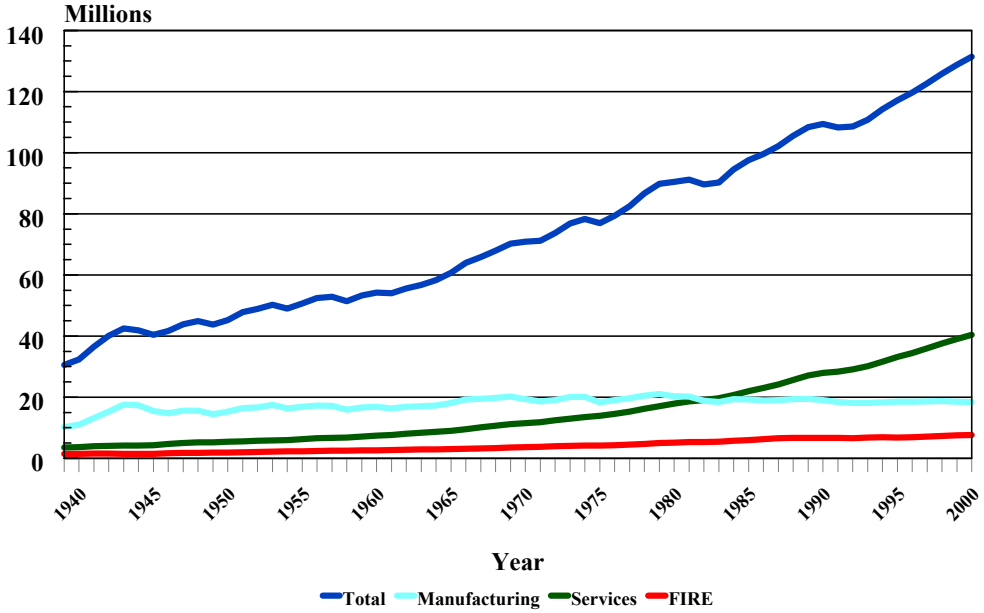
lower than the one shown in Figure 1-6 above because children, who are less likely to experience periods without coverage, are included in the estimate. Overall, it appears that health insurance coverage in Delaware is headed in the right direction and, with the addition of Medicaid managed care and the Childrens Health Insurance Program, the proportion of uninsured Delawareans should fall or at least be stable absent changes in other demographic and economic variables.

Labor Market Issues

Background

Health care coverage is inexorably linked to an individual's employment status along with the type and size of firm for which they work. Many Delawareans have recently experienced more instability in their labor market activity and this has, inevitably, affected aspects of their coverage. The factors producing this increased instability are varied and are both national and international in scope. There are, however, some basic trends that are important to understand since they are affecting and will continue to affect health care coverage in the years to come.

Figure 2-1
US Non-Agricultural Employment:
Selected Sectors 1939-2000

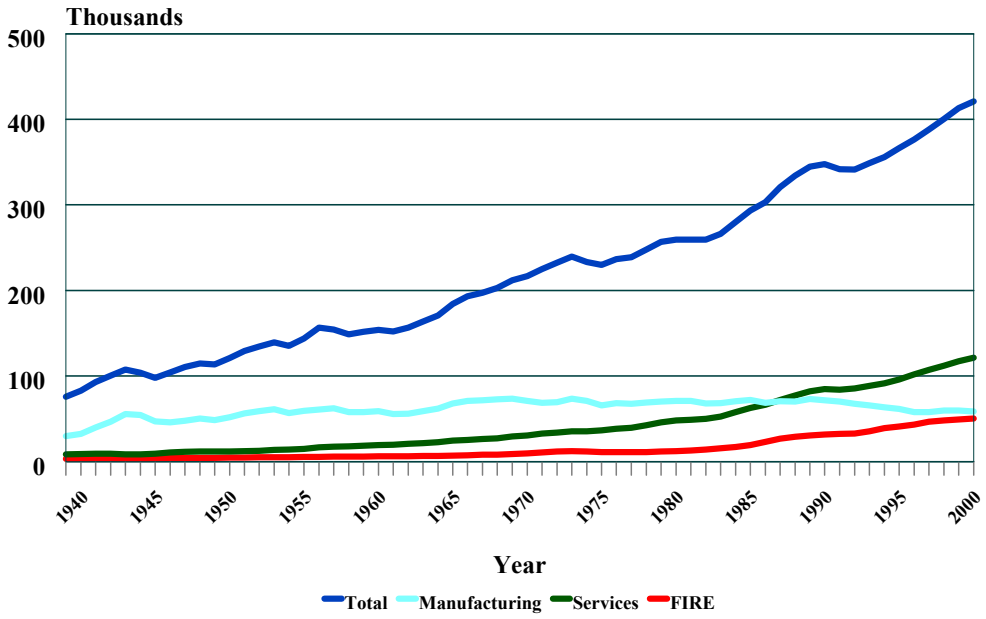


Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Labor Statistics

In Figure 2-1 above, the total employment for the United States from 1939 through 2000 is shown along with three of the ten employment sectors namely: manufacturing, services, and FIRE (finance, insurance, and real estate). The graph clearly shows the impact that the business cycle has had on total employment in the mid-1970s, the early 1980s, and the early 1990s. All of these economic events are associated with rapid increases in the percentage of persons without health coverage. The more subtle influence is related to the change in the structure of

employment. Manufacturing employment reached its peak in the late 1970s and has been in a steady but very shallow decline for the most part. Service industry employment increased steadily over the entire period and began accelerating its growth when manufacturing employment was at its peak. In 1981, service sector employment surpassed manufacturing employment and today it accounts for nearly twice as much employment as manufacturing. This trend will probably continue unabated for the foreseeable future.

Figure 2-2
Delaware Non-Agricultural Employment:
Selected Sectors 1939-2000

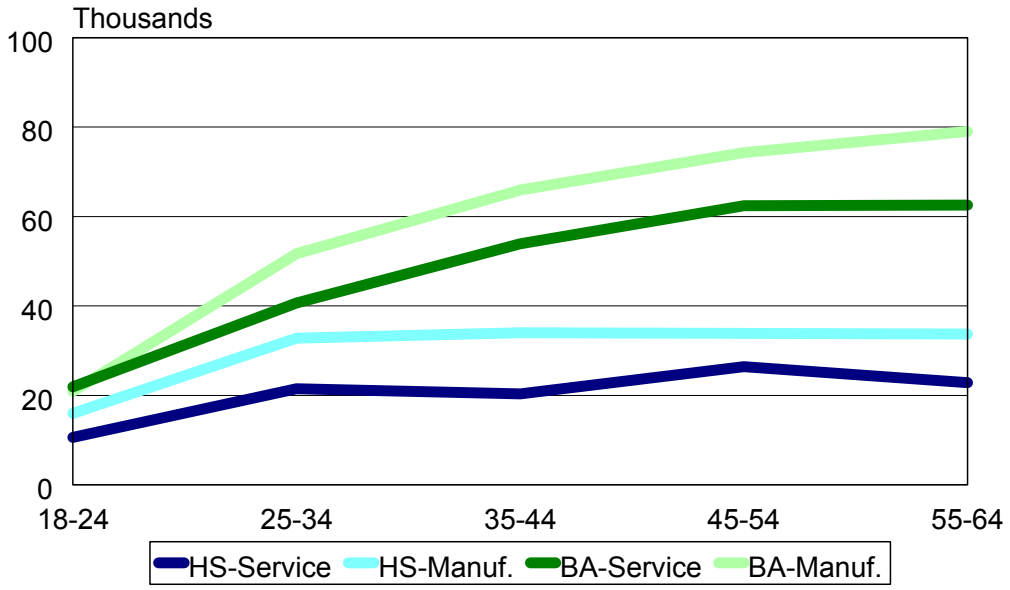


Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Labor Statistics, Delaware Department of Labor

The pattern was similar in Delaware, although the recession of the mid-1970s was more severe and the later ones were perhaps less damaging than they had been nationwide. For instance, statewide manufacturing employment peaked during 1989. This marked the end of the expansion of the 1980s. Since then, the number of manufacturing jobs available to Delawareans has dropped significantly and continues to fall even today. In 1986, four years after it happened nationally, statewide service industry employment surpassed manufacturing employment. The rate of growth in service sector employment in recent years has slowed somewhat compared with the rate for the U.S. but this has been offset by the incredible growth in the FIRE sector.

Employment in the FIRE sector clearly exploded after the passage of the Financial Center Development Act in the early 1980s. It continued to grow dramatically until the 1990-1991 recession. To most observers' surprise, the growth re-ignited in 1992 and continues today. A comparison of the trends in Figure 2-1 and Figure 2-2 show this to be a Delaware phenomenon.

Figure 2-3
Average Annual Earnings by
Sector, Age, and Education in 1998-2000



Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census Current Population Survey, March 2000

The importance of these inter-sector employment shifts is shown in Figure 2-3 above. Figure 2-3 shows the average annual earnings by age, education, and industrial sector. The top two lines represent annual earnings for college graduates in the manufacturing and service sector respectively. The bottom two lines depict the same information for high school graduates in the same two sectors.

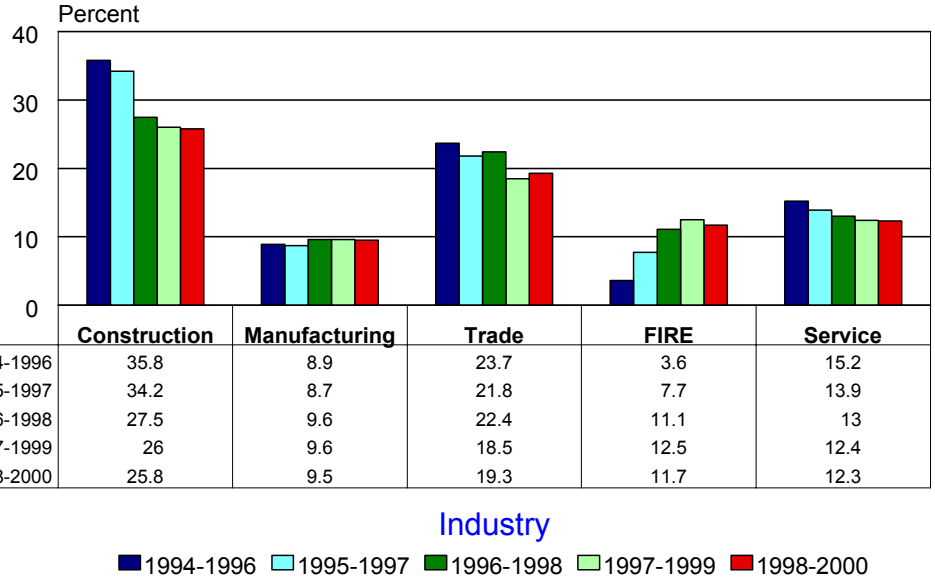
The graph shows a difference of about $40,000 in annual earnings between the two sectors for both levels of education. If the same health care benefits were offered in both sectors, the cost to employers would be a much larger proportion of the annual salary in the service sector than in manufacturing. This suggests that employees in the service sector will likely be offered fewer benefits.

In addition, those employed in manufacturing are much more likely to be represented in a collective bargaining unit, a union. They are also more likely to work full-time with significant overtime, which further reduces the impact of the cost of benefits on total compensation. In contrast, service sector workers are more likely to be employed by non-union companies and are much more likely to work part-time. These factors, coupled with the increasing number of service sector workers relative to the number of manufacturing workers will tend to increase the number of uninsured or under-insured people.

Firm Sector and Size

There are significant differences in both the level and pattern of the uninsured, depending upon the type of industry in which an individual is employed. For instance, according to Figure 2-4 below, construction workers frequently report being uninsured. Although it may be noted that some construction workers are unionized, and are usually provided health coverage, many more are either employed by a non-union company or are self-employed. Overall, it is estimated that more than 25% of all construction workers are uninsured.

Figure 2-4
Percent of Persons without Health Insurance in Delaware by Industrial Sector



	Construction	Manufacturing	Trade	FIRE	Service
1994-1996	35.8	8.9	23.7	3.6	15.2
1995-1997	34.2	8.7	21.8	7.7	13.9
1996-1998	27.5	9.6	22.4	11.1	13
1997-1999	26	9.6	18.5	12.5	12.4
1998-2000	25.8	9.5	19.3	11.7	12.3

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Many persons employed in the trade industry (retail and wholesale) also find themselves without health coverage. Because this sector is not heavily unionized and is reliant on a large number of part-time workers (most of whom do not qualify for a typical health insurance

package), it is not unexpected that an estimated 19% of those employed in the trade industry currently lack health coverage. The most recent data suggests that the upward trend operating since 1994 has moderated.

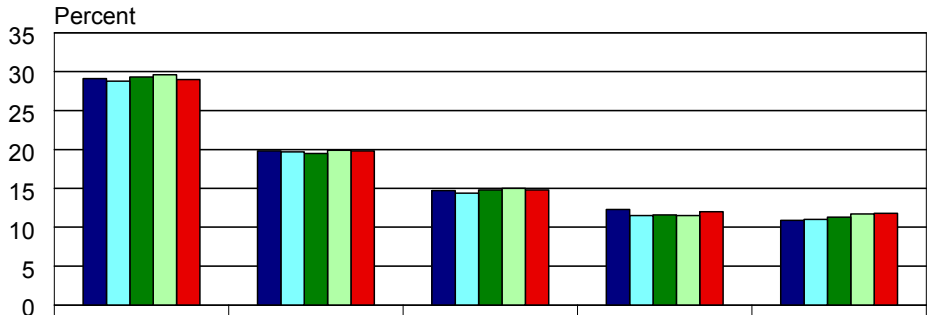
Of the other industries represented in Figure 2-4, approximately 12% of all those employed in the service industry are not offered access to health insurance as part of a benefits package. This number appears to be declining somewhat over the period. This probably reflects the changing nature of the service industry.

Roughly 10% of those employed in manufacturing and FIRE do not have health coverage. However, the proportion uninsured in the FIRE sector appears to be increasing. This could, for example, reflect an increase in full-time temporary employees in this sector

Finally, it also should be pointed out that the differences in coverage between industries are among the largest observed for any variable in this report. The importance of this information relates to the changing structure of the economy. As employment shifts from manufacturing to the service sector, the percentage of uninsured workers increases by about 3%. The importance of the FIRE sector in Delaware cannot be over estimated at least with respect to health coverage, although the 2000 estimates make this conclusion less clear. While the percentage of uninsured in the region has been rising, Delaware's rate has either been falling or remaining steady. This appears, in large part, to be related to the accelerating FIRE sector and to a less rapidly growing service sector.

The other important inter-sector shift, which is more subtle, is associated with the nature of downsizing in Delaware's manufacturing sector. A significant portion of those employees who were "downsized" belonged to headquarters support operations as opposed to the factory floor. In many cases, those same employees started or joined firms that supplied services to their previous employer who simply wanted to "out-source" those functions. Many of these new jobs are classified as business services, part of the service sector, and are far from the typical "hamburger flipper" often discussed in the media. This has produced increases in annual earnings in the service sector that bodes well for benefit programs in the future.

Figure 2-5
Percent of Persons without Health Insurance in the US
by Size of Firm



	Under 25	25-99	100-499	500-999	1000+
1994-1996	29.1	19.8	14.7	12.3	10.9
1995-1997	28.8	19.7	14.4	11.5	11
1996-1998	29.3	19.5	14.8	11.6	11.3
1997-1999	29.6	19.9	15	11.5	11.7
1998-2000	29	19.8	14.8	12	11.8

Size of Firm

1994-1996 1995-1997 1996-1998 1997-1999 1998-2000

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Employees who work for small firms (under 100 employees) are less likely to have health insurance than those that work for large firms (more than 500 employees). Figure 2-5 above shows this relationship.

The graph shows that there are two distinct groupings: (1) firms with less than 100 employees where the percentage without health insurance is 24% and (2) firms with more than 500 employees where the percentage of those without health insurance is 12%. The larger firms are perhaps more likely to be unionized at least to the extent that larger firms have a higher probability of being in sectors such as manufacturing. They are also more likely to pay higher wages, which makes the relative cost of health insurance more tolerable. From a tax perspective, the provision of health insurance also provides a convenient way to increase total compensation.

A somewhat disturbing trend is also evident in Figure 2-5. It appears, at least from the national perspective, that those working for smallest firms are not improving their insurance coverage in comparison with five years ago. What makes this trend so disconcerting is the fact that the economy has been expanding for almost ten years. The same can be said for larger firms, however. One explanation for this lack of improvement is the lack of increases in wages

nationally and the restructuring and cost cutting practiced by most firms, which has produced significant increases in earnings.

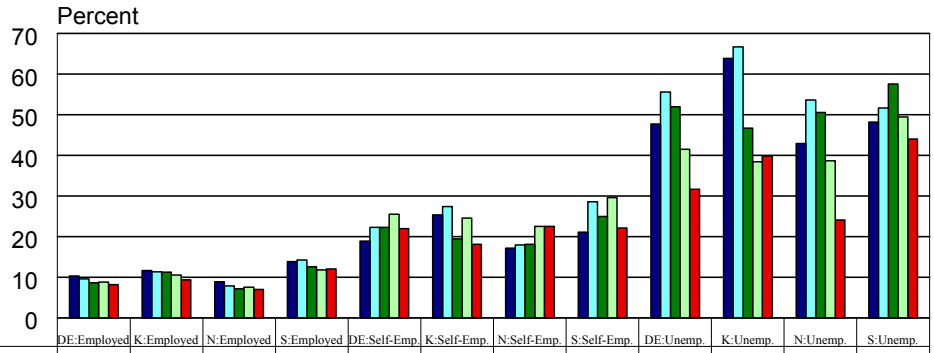
In conclusion, these data suggest that any effort to increase coverage must focus on smaller firms. Those firms will tend to provide lower levels of compensation, will probably use more part-time employees, and may offer less stable employment. However, they are growing faster and becoming a bigger part of the economy. This fact may tend to mitigate some of the negative factors over time. On the other hand, the large firms with better coverage are becoming smaller and that does not help the long-term outlook. There is no doubt, however, that all of these factors will tend to make the goal of better access to health care a challenge for the foreseeable future.

Employment Status and Class

Approximately 75% of all Delawareans are covered by some form of group health insurance. The vast majority is covered through their employer and therefore any disruption in employment will undoubtedly increase the likelihood that coverage will lapse. The reason that coverage may not automatically lapse is because that individual may be covered by another worker in the family, or the coverage may be extended through payments by the employee, or the individual may qualify for some government sponsored plan like Medicaid or Medicare. Still, the disruption is significant as is shown in Figure 2-6, below.

The information reported in Figure 2-6 shows that the probability of being without heath insurance increases by nearly a factor of four when the individual is unemployed. The percentage on the average rises from about 8% to in the vicinity of 32% as the individual's employment status changes. There is considerably more volatility in the estimates in Kent and Sussex counties because of small sample sizes, but the relationship mirrors that in New Castle County where sample size is not a problem. While those that are self-employed are also found in relatively small numbers in the BRFSS survey, the lack of health insurance is at least twice as prevalent as that of those with traditional employment. This year there is little observable difference between the counties with respect to the self-employed.

Figure 2-6
Percent of Adults without Health Insurance in Delaware
by County and Employment Status



	DE:Employed	K:Employed	N:Employed	S:Employed	DE:Self-Emp.	K:Self-Emp.	N:Self-Emp.	S:Self-Emp.	DE:Unemp.	K:Unemp.	N:Unemp.	S:Unemp.
1994-1996	10.3	11.7	8.9	13.9	18.9	25.4	17.2	21.1	47.7	63.9	42.9	48.2
1995-1997	9.6	11.4	7.9	14.3	22.3	27.4	18	28.6	55.6	66.7	53.6	51.7
1996-1998	8.7	11.3	7.2	12.6	22.3	19.5	18.1	25	52	46.7	50.6	57.6
1997-1999	8.8	10.6	7.6	11.8	25.5	24.6	22.5	29.6	41.5	38.4	38.7	49.5
1998-2000	8.2	9.4	7	12.1	22	18.1	22.5	22.1	31.7	39.9	24.1	44

Employment Status by County

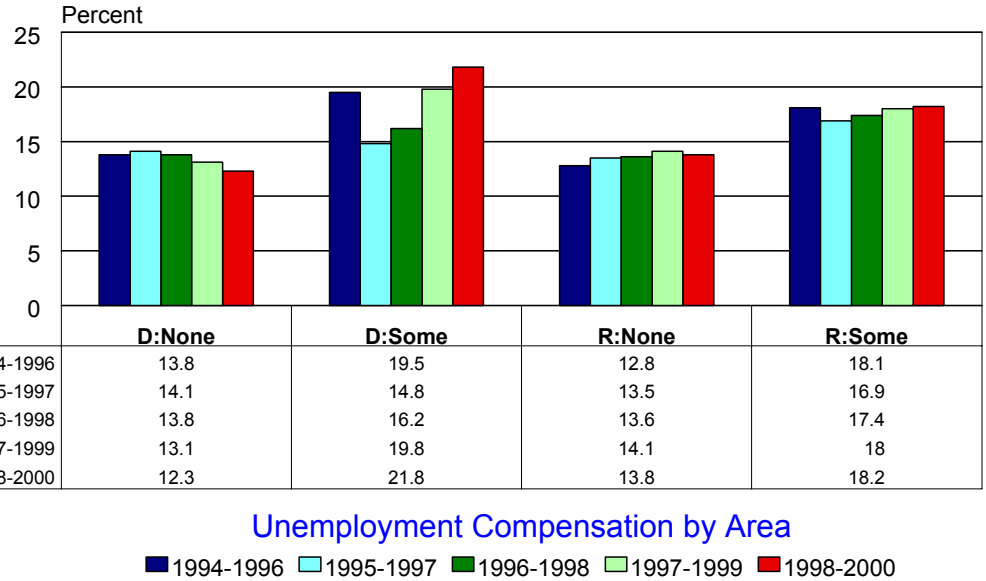
1994-1996 1995-1997 1996-1998 1997-1999 1998-2000

Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Health and Social Services, 1994-2000 Behavioral Risk Factor Survey

The other piece of information that deserves comment is the relative differences between the lack of coverage for employed workers in the three counties. The rate in New Castle County is significantly lower than those observed in Kent and Sussex counties. Following the earlier argument, this probably arises from differences in the economic base, since larger firms with higher wages and more stable employment are located primarily in the northern part of the state.

In Figure 2-7 below, further evidence is found about the relationship between insurance coverage and employment status. In this analysis, the receipt of unemployment compensation is used as an indicator of an interruption of employment at some point during the year. In both Delaware and the region, there is a significant rise in the lack of health coverage associated with receiving benefits. While the effect is more muted than in Figure 2-6, where a more direct measure was available, the percentage is always higher in the region where the sample size permits a better estimate.

Figure 2-7
Percent of Persons without Health Insurance
by Receipt of Unemployment Compensation and Area



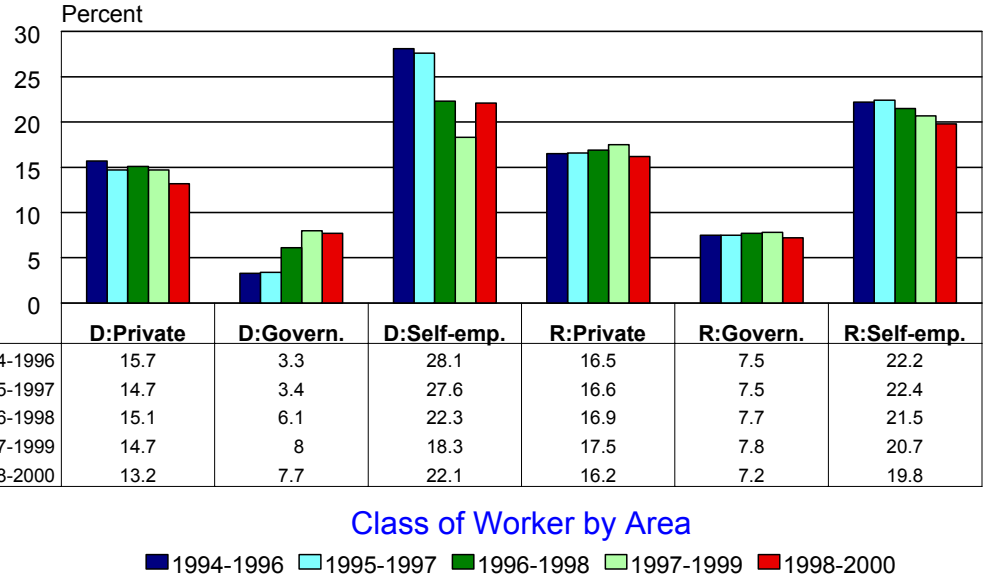
	D:None	D:Some	R:None	R:Some
1994-1996	13.8	19.5	12.8	18.1
1995-1997	14.1	14.8	13.5	16.9
1996-1998	13.8	16.2	13.6	17.4
1997-1999	13.1	19.8	14.1	18
1998-2000	12.3	21.8	13.8	18.2

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

The final graph in this section of the report represents the percentage of workers without health insurance in Delaware and the region as indicated by three broad classes namely: private sector workers, government workers, and the self-employed. In Figure 2-8 below, Delaware workers in the private sector average 3% fewer uninsured than those in the region. Within the private sector, Delaware seems to be improving slightly over the time period, which is consistent with the increase in workers in the FIRE sector. The rates in the region, for the private sector, are increasing, which probably reflects increases in the service sector and in part-time employees. Both trends should be watched carefully.

It is no surprise that government employees both in Delaware and the region are far more likely to have health insurance than the private sector in general. Government rates are comparable with very large private sector firms operating in a unionized work place. The only government workers who are likely to lack coverage are temporary/part-time workers or private contractors.

Figure 2-8
Percent of Persons without Health Insurance
by Class of Worker and Area



	D:Private	D:Govern.	D:Self-emp.	R:Private	R:Govern.	R:Self-emp.
1994-1996	15.7	3.3	28.1	16.5	7.5	22.2
1995-1997	14.7	3.4	27.6	16.6	7.5	22.4
1996-1998	15.1	6.1	22.3	16.9	7.7	21.5
1997-1999	14.7	8	18.3	17.5	7.8	20.7
1998-2000	13.2	7.7	22.1	16.2	7.2	19.8

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

A more interesting structural shift, which has been underway for some time, is that government workers are representing a smaller proportion of the labor force, since that sector is growing less rapidly than employment overall. This implies that the percentage of uninsured workers will tend to rise, even if all the rates within these classes remain constant.

The information about the self-employed corroborates the information from the BRFSS discussed earlier. The data for the region, however, shows that the significant upward trend previously identified has moderated. There are a variety of potential explanations. One reason, which is consistent with other data, is that tight labor markets have allowed many of those previously classified as "self-employed" to find work and to gain benefits. Those that remain self-employed are likely to be financially stronger and better able to obtain health insurance.

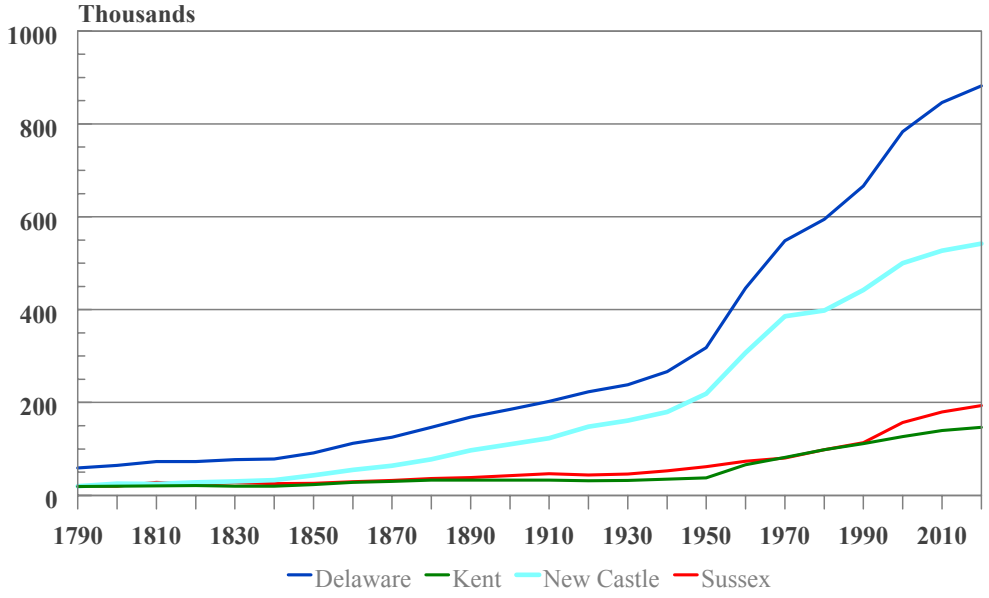
Demographic Characteristics

Background

Labor market characteristics are only some of the variables that play a role in influencing the proportion of people without health insurance. Demographic variables also may help explain a population's lack of health insurance. Others simply provide a convenient method for describing this condition among subsets of the population. Both will be addressed in this section.

Before returning to the health insurance issue, a few important factors driving population growth need to be addressed. In the first section of the report, it was reported that the number of uninsured had remained reasonably stable while the population increased substantially. There are, however, some recent indications, also discussed in the previous section, that future population increases could be accompanied by increasing numbers of uninsured. For that reason, it is important to understand how Delaware is growing.

Figure 3-1
Population of Delaware and Counties



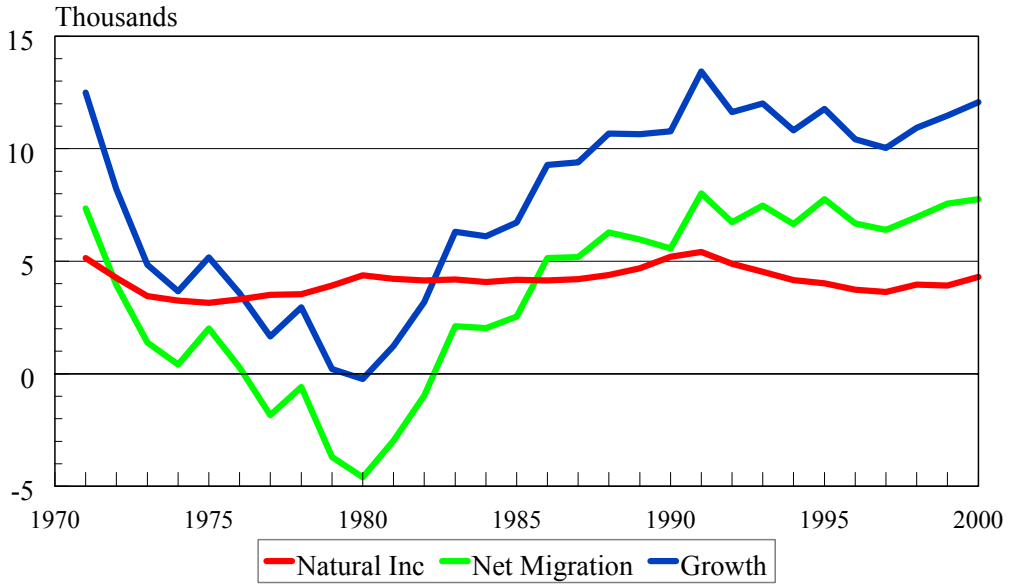
Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Decennial Census 1790-2000
Delaware Population Consortium, June 2000

In Figure 3-1 above, the pattern of population growth for the state and for each county is shown from the first U.S. census in 1790 through the current 30-year projection in 2020. The state grew at a fairly steady rate from 1840 to 1950, when population growth began to explode.

This pattern continued unabated for 20 years until the oil-crisis induced recession and the migration to the sun-belt began. Population growth resumed in 1980, although at a much slower rate, and is predicted to continue to grow at rates around 1% annually. Kent County continues to grow slowly at rates that are consistent with those of the state in the last century. However, Sussex County has been growing at a rate of 3% per year, which approaches those observed in New Castle County during 1950-1970.

If current conditions continue, this population growth would likely generate another 15,000-20,000 uninsured persons over the next 20 years. But, current conditions, especially those in the labor market, are unlikely to continue. In fact, global competition and pressure on production costs may cause employers to rethink the total compensation package. The structural changes in the labor market alone will probably lead to an increase in the uninsured. Legislative changes and innovative government programs may also act to mitigate any increase in those numbers. However, it is difficult to speculate as to how these different factors will average out.

Figure 3-2
Sources of Population Growth in Delaware



Source: Center for Applied Demography and Survey Research, University of Delaware

Figure 3-2 above illustrates the components of Delaware's population growth since 1980. The darkest line in the graph represents annual population growth. It has been as little as 2,000 persons in 1982, at the end of the recession, and as much as 13,000 persons when the economy peaked in 1989.

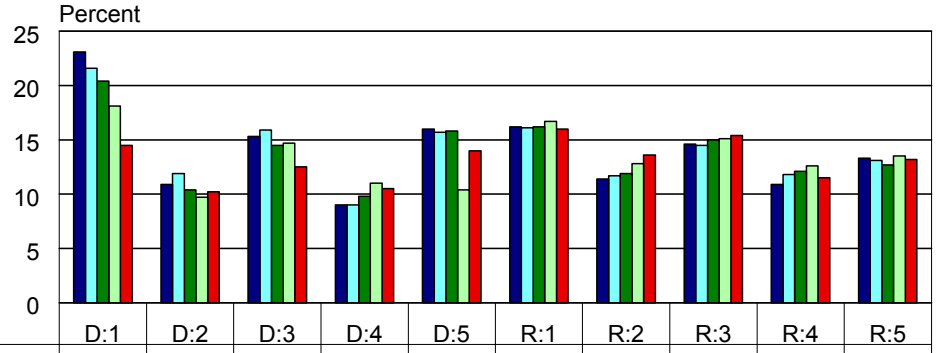
Overall growth is dependent upon two components: natural increase and net migration. Natural increase is the number of births to Delaware residents less the number of Delaware residents that die. That quantity is represented by the lightest curve in Figure 3-2 and has been around 4,000 per year until the "baby boomlet" started in 1985 and ended in 1991.

Net migration, which is the result of persons moving into Delaware less persons moving out of Delaware, is clearly the volatile component of the growth picture. It has moved from net out-migration in 1982 of -2000 to a high of +8000 net in-migration at the peak of the economic cycle. It then fell during the recession years of the early 1990s and today accounts for about half of all population growth. From these data, it is easy to see that Delaware's population growth is heavily influenced by local labor market conditions. Delaware's economy has consistently produced unemployment rates below those for the nation and region and has continued to generate new jobs sufficient to attract net in-migration. The characteristics of those jobs, in particular their health benefits, can and probably have affected coverage rates in Delaware.

Household Composition

The size and structure of the households, within which individuals live, has much to do with the probability of having health care coverage. Each of the variables addressed in this section, to include household size, marital status, and relationship to head of household, give a slightly different slant on the problem. Figure 3-3 below, contains information about the percentage of uninsured in relation to household size within Delaware and the region. The most disadvantaged group is the single person household. The percentage of uninsured is 7% above the proportions for most of the other categories. Single person households also fare somewhat worse in Delaware than in the region. Those individuals are somewhat disadvantaged since there is no second worker in the household to share the risk of losing coverage. They are also more likely to be a younger person at the low-end of the life cycle of earnings and are more likely to work in a job that does not provide health insurance coverage. Of course, the rate is reduced somewhat by older persons living alone who are covered by Medicare.

Figure 3-3
Percent of Persons without Health Insurance
by Household Size and Area



	D:1	D:2	D:3	D:4	D:5	R:1	R:2	R:3	R:4	R:5
1994-1996	23.1	10.9	15.3	9	16	16.2	11.4	14.6	10.9	13.3
1995-1997	21.6	11.9	15.9	9	15.7	16.1	11.7	14.5	11.8	13.1
1996-1998	20.4	10.4	14.5	9.8	15.8	16.2	11.9	15	12.1	12.7
1997-1999	18.1	9.7	14.7	11	10.4	16.7	12.8	15.1	12.6	13.5
1998-2000	14.5	10.2	12.5	10.5	14	16	13.6	15.4	11.5	13.2

Household Size by Area

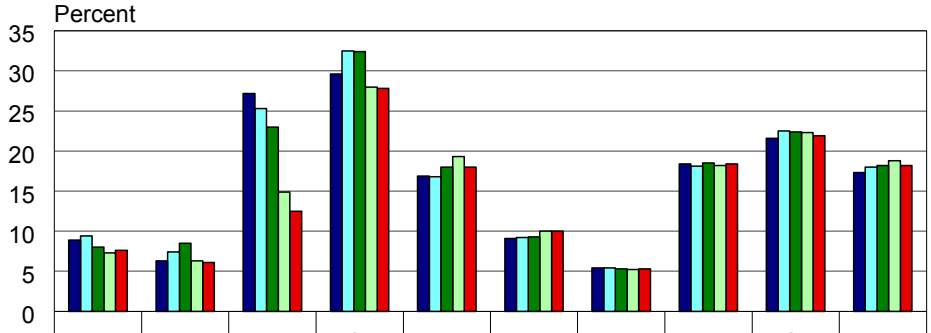
1994-1996 1995-1997 1996-1998 1997-1999 1998-2000

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Two and four person households were least likely to report lacking health coverage. The two-person household has a high probability of being a married couple with two incomes. The four-person household is also likely to have two working adults within it. The three-person household is a mixed picture since it also includes a single parent with two minor children, thus the risk of being without coverage rises. Overall the relationship between household size and the lack of health insurance coverage in Delaware tracks well with that of the region.

Marital status is closely linked to household size and composition. This relationship can be easily seen in Figure 3-4 below. For instance, the lowest rates observed over the period, usually under 6%, are reported by the widowed. This is expected since the largest majority of this group is qualified for Medicare. Thus, age may have more to do with their higher insurance rate than marital status. Married people have the next lowest rate with less than 8%. Married couples, with or without children, usually have two chances to obtain coverage. That may not be true if one spouse is not in the labor force or only works part-time. Still, the probabilities of having health insurance increases and household members are more likely to be protected against the loss of coverage during times when one or the other is unemployed.

Figure 3-4
Percent of Persons without Health Insurance
by Marital Status and Area



	D:Mar.	D:Wid.	D:Div.	D:Sep.	D:Nev.	R:Mar.	R:Wid.	R:Div.	R:Sep.	R:Nev.
1994-1996	8.9	6.3	27.2	29.6	16.9	9.1	5.4	18.4	21.6	17.3
1995-1997	9.4	7.4	25.3	32.5	16.8	9.2	5.4	18.1	22.5	18
1996-1998	8	8.5	23	32.4	18	9.3	5.3	18.5	22.4	18.2
1997-1999	7.3	6.3	14.9	28	19.3	10	5.2	18.2	22.3	18.8
1998-2000	7.6	6.1	12.5	27.8	18	10	5.3	18.4	21.9	18.2

Marital Status by Area

1994-1996 1995-1997 1996-1998 1997-1999 1998-2000

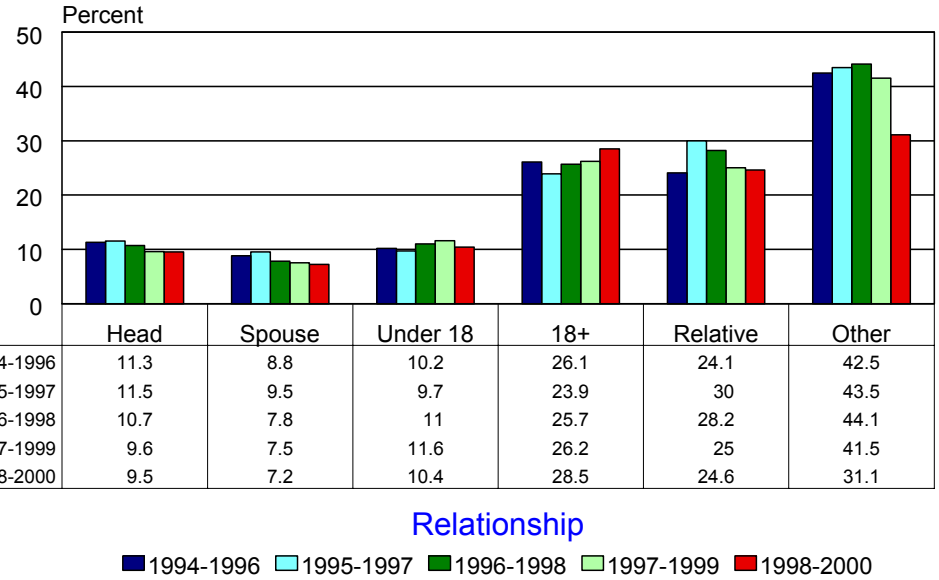
Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Younger adults heavily populate the "never married" category and, as will be explained later, are less likely to have coverage. For this reason, their risk of being uninsured is more than twice that of a married person.

The last two groups, which are usually one-adult households, are interesting for different reasons. First, the "separated" group in Delaware is quite volatile, however on the average the risk is higher than that observed for the younger, "never married" category. This group is typically a transitional one and the person will probably move on to the divorced category. The separated person's lack of coverage is less than that of the divorced person because some may be able to legally retain coverage until a final disposition of the marriage is reached. Once the person is divorced, the probability of having coverage will depend in large part on the person's labor force status. It should be kept in mind that a significant number of people in this category are making major transitions and may suffer significant income losses. Interestingly, Delawareans in this category are significantly worse off than their regional counterparts. Given the similarity in all of the other categories, this difference does stand out, although it is not at all clear why there should be such a difference.

Figure 3-5

Percent of Persons without Health Insurance in Delaware by Relationship to Head



	Head	Spouse	Under 18	18+	Relative	Other
1994-1996	11.3	8.8	10.2	26.1	24.1	42.5
1995-1997	11.5	9.5	9.7	23.9	30	43.5
1996-1998	10.7	7.8	11	25.7	28.2	44.1
1997-1999	9.6	7.5	11.6	26.2	25	41.5
1998-2000	9.5	7.2	10.4	28.5	24.6	31.1

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

The final demographic variable in this series is relationship to the head of household. Figure 3-5 above depicts its association with the risk of being without health insurance. There are, once again, two distinct groupings. First, there are the typical adults and minor children whose risk levels are around 10%. (This group of children excludes many who are not the children of the head of household but are living in the house.) The head group also includes all of those single person households whose risks were also elevated. This is the reason why the spouse group has about a 2% less risk of being without health insurance. Minor children are dependent on the adult(s) health insurance coverage and there may be either one or two adults in the household. Thus, the risk will always be higher than that for the spouse group where there must be two married adults in the household.

The second major grouping includes adult offspring who are living at their parent's home, relatives or non-related persons. The risk level for all three groups is more than twice that of the first group. With the exception of full-time students who still might be covered by their parent's insurance, all will require health insurance through some other means. The fact that they are adults living in a household where they are neither the head or spouse in the household suggests that they are less likely to be active labor force participants. In addition, there are many children in these groups as well.

Taken together these demographic variables point in the same direction. Does the person have multiple opportunities to obtain health insurance coverage? For instance, households that contain two married adults have a lower risk not only for themselves, but also for any minor children. Unfortunately, demographic trends do not favor this model. First, from 1980 to 1990 the number of single person households rose from 21% of all households to 23% and is continuing to grow. Second, those living in non-family households rose from 11% in 1980 to 13% in 1990. The number of married couple households with or without children has fallen from 61% in 1980 to 57% in 1990. Finally, the number of children under the age of 18 living with only one parent has risen from 19% to 21% over the decade. None of these trends favors reducing the risk of being without health insurance coverage and it is unlikely that those trends will be easily reversed.

Age Structure

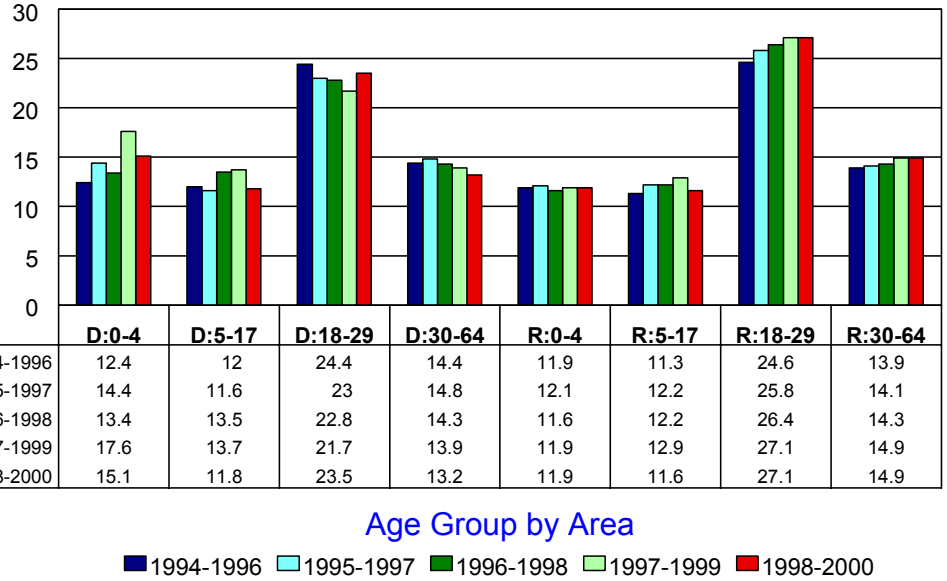
By and large, age appears to be a factor that influences the probability a person has health coverage. The most obvious example is the relationship between age and one's eligibility to qualify for Medicare, i.e. the person is 65 years old or older. Thus, the question for that age group must focus on the extent of coverage and not on its existence.

Because the majority of persons 65 years and older have access to health coverage, only the percentage of persons without health insurance coverage for the other age groups is found in Figure 3-6 below. In both Delaware and the region, dependent children, those under the age of 18, have the lowest risk of being uninsured. Only about 13% of them are estimated to lack health coverage. Their uninsured rate is somewhat higher than it was in Figure 3-5, which imposed the additional requirement that they also live in and were related to the head of household. Thus, it should be remembered that the following graph contains information for all children, regardless of their living arrangement. Only recently have these measurements been influenced by the CHIP program.

For a variety of reasons, persons aged 18-29 were most likely to report being uninsured. In both the state and the region, the risk of not having health coverage for this group exceeds 23% and there is no sign of improvement in the time series and it may be worsening. This group suffers from a multitude of disadvantages. First, they are more likely to be unmarried. Second, they are more likely to hold lower paying jobs which provide no health benefits. Third, because their income levels are generally lower, it is often difficult for them to purchase private

insurance. Fourth, since they are generally healthy, it may seem reasonable not to expend the additional resources needed to purchase health coverage. As this group ages into the next group, aged 30-64, the risk begins to fall as those disadvantages recede.

Figure 3-6
Percent of Persons without Health Insurance
by Age Group and Area



	D:0-4	D:5-17	D:18-29	D:30-64	R:0-4	R:5-17	R:18-29	R:30-64
1994-1996	12.4	12	24.4	14.4	11.9	11.3	24.6	13.9
1995-1997	14.4	11.6	23	14.8	12.1	12.2	25.8	14.1
1996-1998	13.4	13.5	22.8	14.3	11.6	12.2	26.4	14.3
1997-1999	17.6	13.7	21.7	13.9	11.9	12.9	27.1	14.9
1998-2000	15.1	11.8	23.5	13.2	11.9	11.6	27.1	14.9

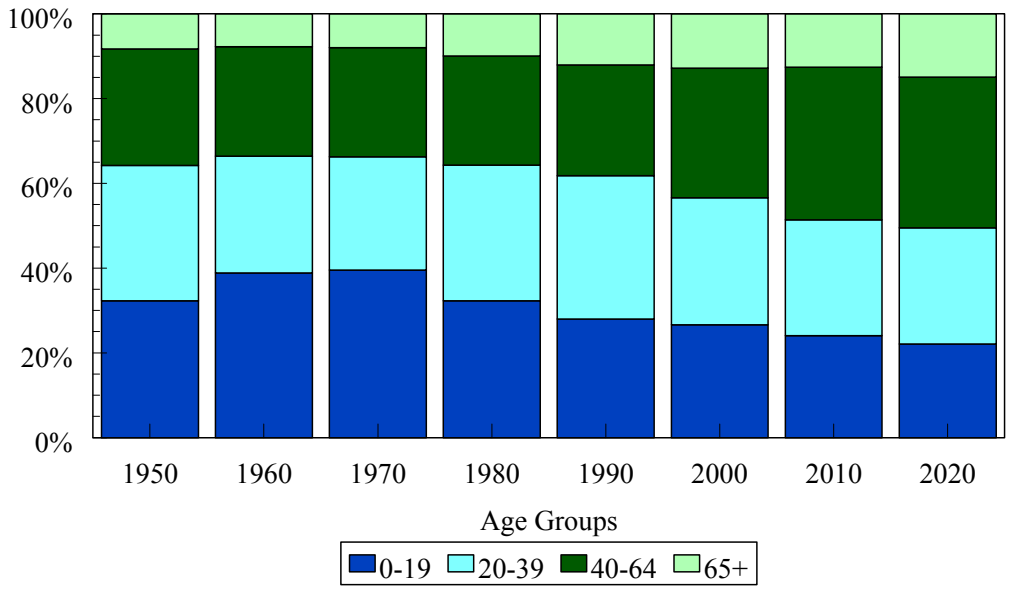
Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Given these very predictable differences, the way the age distribution changes over time will have a definite impact on the overall level of health insurance coverage in Delaware. This progression is found in Figure 3-7 below. In 1990, the largest age group is 20-39 and contains about 30% of the population. By the year 2010, however, the largest group is 40-64. Their ranks are being swollen by net in-migration, which disproportionately affects those under the age of 50 and the movement of the baby boomers through time.

There are several observations to be made about Figure 3-7 below. First, the proportion of the population ages 0-19 and 20-39 decreases steadily over the coming decades. The falling numbers in this group are part of the reason Delaware's health coverage rates have been stable. As the proportion of population in the two oldest groups increases, overall risk of being uninsured will fall. As the "baby boomers" age (and they represent a significant part of the age distribution), their overall risk level should decrease. The real issue, therefore, will be economic

conditions in the state and in the nation as this huge group reaches what would normally be their peak earning years.

Figure 3-7
Age Structure in Delaware
1950-2020



Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Population Consortium, June 2000

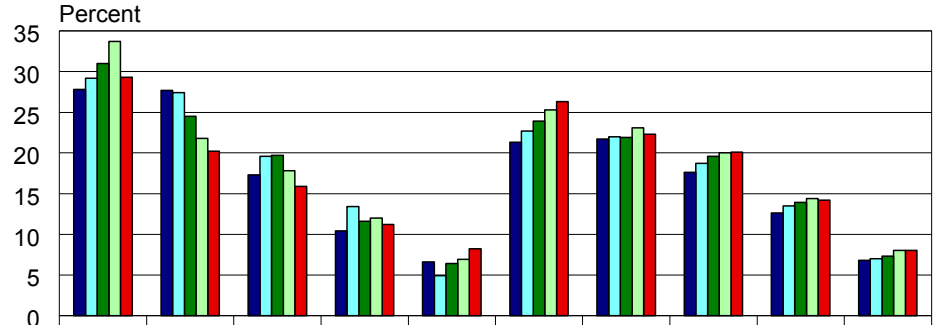
Will they be the victims of another round of downsizing? Will they become frustrated with the lack of advancement since there are so many competing for the same jobs? Will they turn to self-employment as a means of increasing their standard of living? All of these are unknown at this point but are likely to have an effect either positive or negative on health insurance coverage. This aging population will also put pressure on health care costs and will probably alter the behavior of employers.

Income and Education

Economic well-being has two different effects on the probability of having health insurance coverage. At the low end of the income spectrum, there are programs such as Medicaid available as part of the social safety net. Individuals at the high end of the income spectrum have the assets and income that allow them to be unconcerned about insuring their health. They can afford to take the risk. The biggest problem arises among those that do not qualify for a government program, cannot afford insurance, and certainly cannot pay the medical bills if their

luck runs out. Figure 3-8 below provides data with respect to annual income and lack of health insurance.

Figure 3-8
Percent of Persons without Health Insurance
by Household Income and Area



	D:$10K-	D:$10K-20K	D:$20K-30K	D:$30K-50K	D:$50K+	R:$10K-	R:$10K-20K	R:$20K-30K	R:$30K-50K	R:$50K+
1994-1996	27.8	27.7	17.3	10.4	6.6	21.3	21.7	17.6	12.6	6.8
1995-1997	29.2	27.4	19.6	13.4	4.9	22.7	22	18.7	13.5	7
1996-1998	31	24.5	19.7	11.6	6.4	23.9	21.9	19.6	13.9	7.3
1997-1999	33.7	21.8	17.8	12	6.9	25.3	23.1	20	14.4	8
1998-2000	29.3	20.2	15.9	11.2	8.2	26.3	22.3	20.1	14.2	8

Income Level by Area

1994-1996 1995-1997 1996-1998 1997-1999 1998-2000

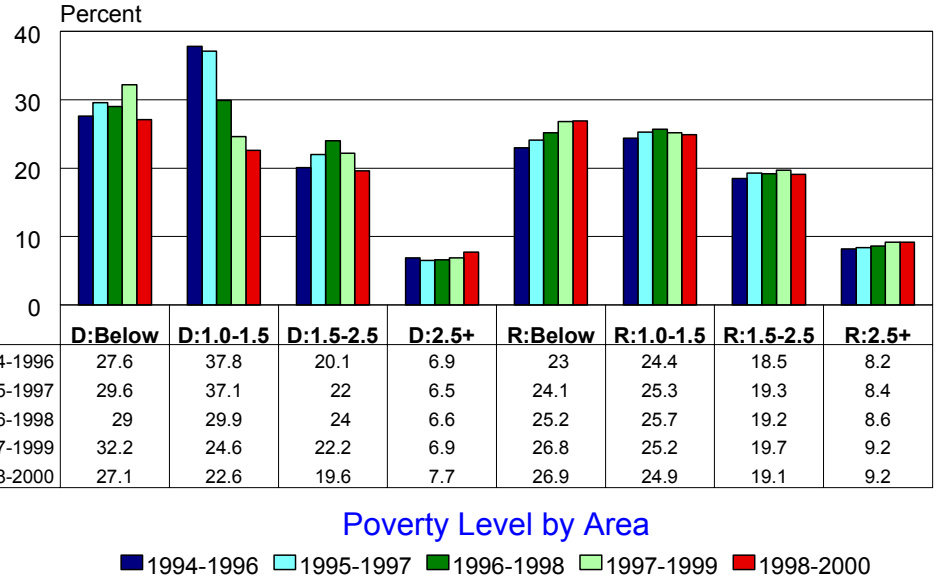
Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Persons whose annual income is under $20,000 per year have a risk more than 1 in 4 of being without health insurance coverage. In the lowest income category, Delaware seems to average about 6% higher than the region as a whole. As income increases, the percentage of persons without coverage falls. At the $50,000 and over level, about 8% or 1 in 12 are without health insurance and some of those may have sufficient assets to warrant self-insurance. This strong relationship undoubtedly represents the fact that health insurance as a percentage of total compensation falls as income rises and thus holders of those jobs are likely to be given those benefits.

Poverty is a function of two variables, household income and household size. It is poverty status that tends to be used to define who is eligible for government health insurance programs. In Figure 3-9 below data are found relating poverty to the lack of health insurance coverage. There seems to be very little difference between those below poverty and the near poverty group, which is between 1.0 and 1.5 of the poverty level. The effect of Medicaid serves

to keep the rate somewhat lower for those below poverty than it would be in the absence of the program. Some people in the second group also qualify for Medicaid, but the proportion is smaller than in the below poverty group. The trend for the lowest group is in the wrong direction.

Figure 3-9
Percent of Persons without Health Insurance
by Poverty Level and Area



	D:Below	D:1.0-1.5	D:1.5-2.5	D:2.5+	R:Below	R:1.0-1.5	R:1.5-2.5	R:2.5+
1994-1996	27.6	37.8	20.1	6.9	23	24.4	18.5	8.2
1995-1997	29.6	37.1	22	6.5	24.1	25.3	19.3	8.4
1996-1998	29	29.9	24	6.6	25.2	25.7	19.2	8.6
1997-1999	32.2	24.6	22.2	6.9	26.8	25.2	19.7	9.2
1998-2000	27.1	22.6	19.6	7.7	26.9	24.9	19.1	9.2

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Overall, the percentage of persons without health insurance falls as the distance from the below poverty group increases. The lowest level of risk appears to be experienced by households with incomes above $45,000, the median household income in Delaware. Finally, the rates in Delaware are roughly comparable to those in the region. However, there does seem to be a steady increase in the proportion of persons in the poverty group in Delaware, while the regional proportion has remained consistently lower but increasing.

Table 3-1
Cumulative Persons by Poverty Status, Age Group, and Health Insurance Coverage
(3-year average 1998-2000)

Poverty	0-18 All	0-18 No HI	19+	19+ No HI
under 0.50	14,785	4,209	16,540	6,466
0.50 to 0.74	26,240	6,397	28,274	9,499
0.75 to 0.99	36,497	8,016	43,287	13,695
1.00 to 1.24	48,031	11,147	60,463	17,402
1.25 to 1.49	54,419	12,427	76,385	21,704
1.50 to 1.74	70,740	18,449	100,036	28,170
1.75 to 1.99	80,294	20,241	121,903	31,924
2.00 to 2.49	102,377	22,279	165,229	39,030
2.50 to 2.99	126,510	25,141	219,391	48,787
3.00 to 3.49	143,331	25,745	261,453	51,206
3.50 to 3.99	161,629	26,611	309,511	56,238
4.00 to 4.49	174,559	27,046	342,752	58,661
4.50 to 4.99	182,125	27,248	371,244	61,531
5.00 & over	218,698	28,930	549,571	71,494

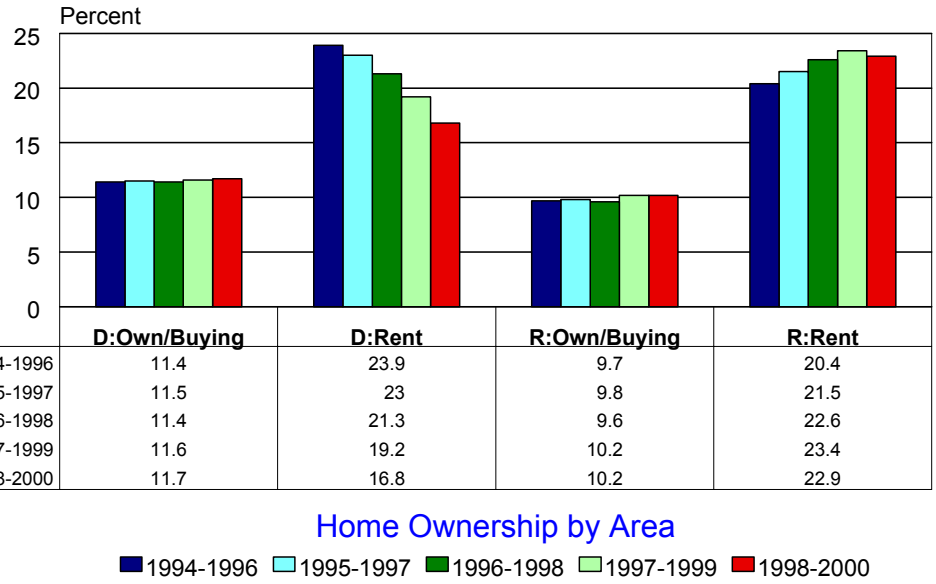
Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1998-2000

In Table 3-1 above, the cumulative distribution of persons by poverty, age, and health insurance status is shown. A three-year moving average is used to reduce the sampling variability.

These data have particular meaning for those charged with providing healthcare to those 18 years and younger in Delaware. The table shows that an estimated 28,930 are without health insurance. Of those, only 8,016 are officially classified as being under the poverty line, and just over 30% are above 2.00 times the poverty line.

Another measure of economic wellbeing is the accumulation of assets. One such measure of that accumulation is home ownership. Those results are found in Figure 3-10 below. The graph shows that for renters, the percentage of those without coverage is twice the rate for those who own or are buying their principal place of residence. That pattern is confirmed by the results for the region, which are quite comparable to those reported for Delaware. Certainly, this finding is not unexpected given that renters tend to be younger and have lower incomes, both

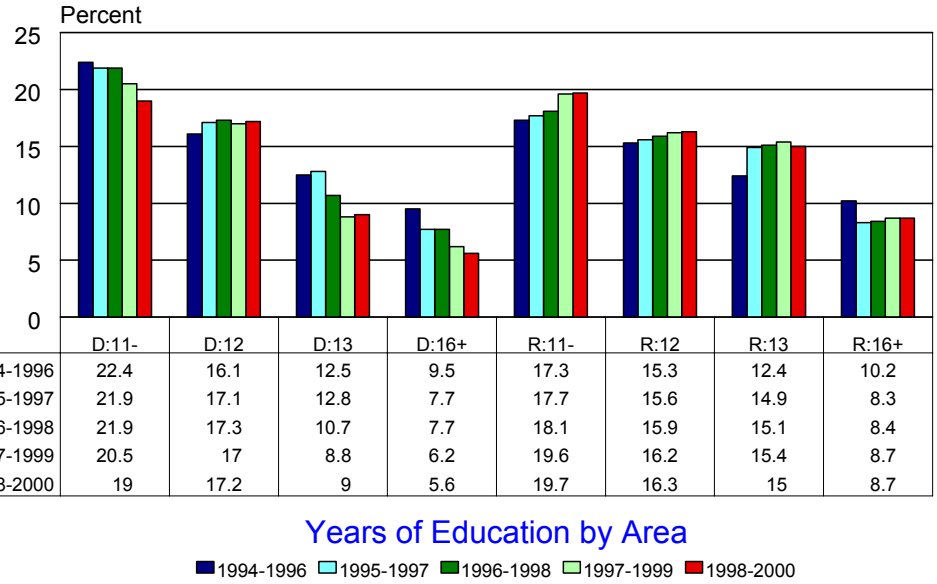
Figure 3-10
Percent of Persons without Health Insurance
by Home Ownership and Area



	D:Own/Buying	D:Rent	R:Own/Buying	R:Rent
1994-1996	11.4	23.9	9.7	20.4
1995-1997	11.5	23	9.8	21.5
1996-1998	11.4	21.3	9.6	22.6
1997-1999	11.6	19.2	10.2	23.4
1998-2000	11.7	16.8	10.2	22.9

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Figure 3-11
Percent of Persons without Health Insurance
by Years of Education and Area



	D:11-	D:12	D:13	D:16+	R:11-	R:12	R:13	R:16+
1994-1996	22.4	16.1	12.5	9.5	17.3	15.3	12.4	10.2
1995-1997	21.9	17.1	12.8	7.7	17.7	15.6	14.9	8.3
1996-1998	21.9	17.3	10.7	7.7	18.1	15.9	15.1	8.4
1997-1999	20.5	17	8.8	6.2	19.6	16.2	15.4	8.7
1998-2000	19	17.2	9	5.6	19.7	16.3	15	8.7

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1993-2000

factors that are correlated with higher risk. They are also less likely to have the assets to continue their insurance privately if there is an interruption in coverage.

The final figure in this section, Figure 3-11 above, relates the educational level of the respondent and their health insurance status. Education could have two significant effects on health insurance coverage. First, it is possible that more educated people are better able to understand the advantages and disadvantages of health coverage and therefore, make better decisions. More likely, however, education is having an indirect effect with higher education being correlated with higher incomes and better jobs/benefits.

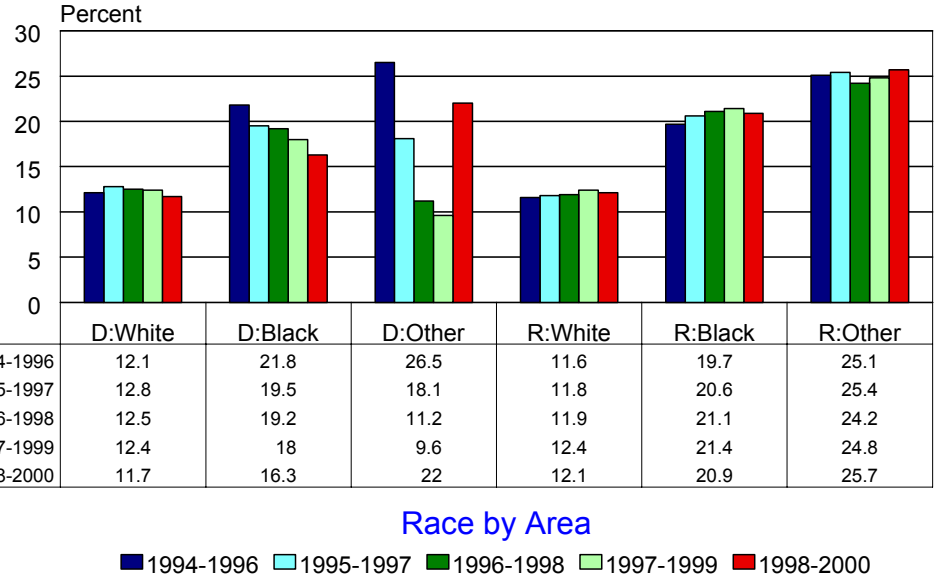
Coverage rates increase significantly as educational level increases. Predictably, those without a high school diploma are the most at risk of being without health insurance. It appears that the most disadvantaged group fares about the same in Delaware as in the region. The uninsured rate falls by 2% for a high school diploma, another 8% for post high school education and finally 3% for those completing college.

Race and Hispanic Origin

Health insurance coverage or lack thereof within sub-groups of the general population is shown in Figure 3-12 below to illustrate the impact of all the underlying contributing variables which determine who has health insurance coverage and who does not. Most of the research in this area suggests that there are significant differences, but do not report any divergence in cultural or risk-taking characteristics that would explain those differences. Thus, the differences are the result of other variables, which themselves differ within segments of the population.

There are significant differences between the three racial groups. Those respondents who classify themselves as black have nearly a 40% higher risk of being without health insurance coverage as those that report being white. However, the historical trend has been decreasing for African-Americans. The “other” category includes primarily Native Americans, Asians, those of mixed race, and those who do not find any of the categories listed to be appropriate. Overall, these rates throughout are consistent between Delaware and the larger region.

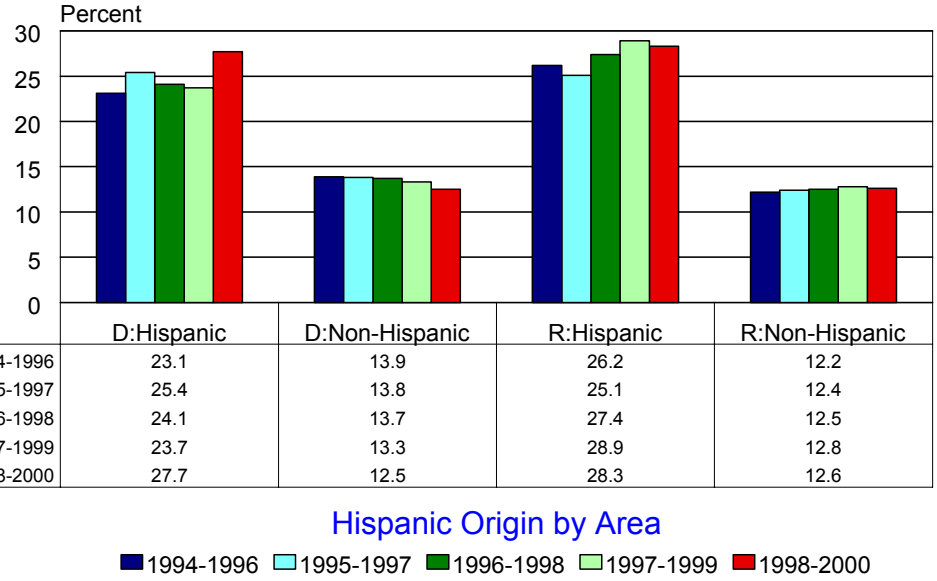
Figure 3-12
Percent of Persons without Health Insurance
by Race and Area



	D:White	D:Black	D:Other	R:White	R:Black	R:Other
1994-1996	12.1	21.8	26.5	11.6	19.7	25.1
1995-1997	12.8	19.5	18.1	11.8	20.6	25.4
1996-1998	12.5	19.2	11.2	11.9	21.1	24.2
1997-1999	12.4	18	9.6	12.4	21.4	24.8
1998-2000	11.7	16.3	22	12.1	20.9	25.7

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1993-2000

Figure 3-13
Percent of Persons without Health Insurance
by Hispanic Origin and Area



	D:Hispanic	D:Non-Hispanic	R:Hispanic	R:Non-Hispanic
1994-1996	23.1	13.9	26.2	12.2
1995-1997	25.4	13.8	25.1	12.4
1996-1998	24.1	13.7	27.4	12.5
1997-1999	23.7	13.3	28.9	12.8
1998-2000	27.7	12.5	28.3	12.6

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

The results for Hispanic respondents are shown in Figure 3-13, above. The percentages within Delaware are quite volatile because of the small sample size, but on average during the period, slightly less than 28% of those respondents who classify themselves as being of Hispanic origin are without health insurance coverage. This rate is more than double that for non-Hispanics. In 2000, just more than 10% of all the uninsured are estimated to be Hispanic. The regional results are similar to those found in Delaware.

Observations

Those lacking health care coverage in Delaware are a diverse group. This is summarized by the list below:

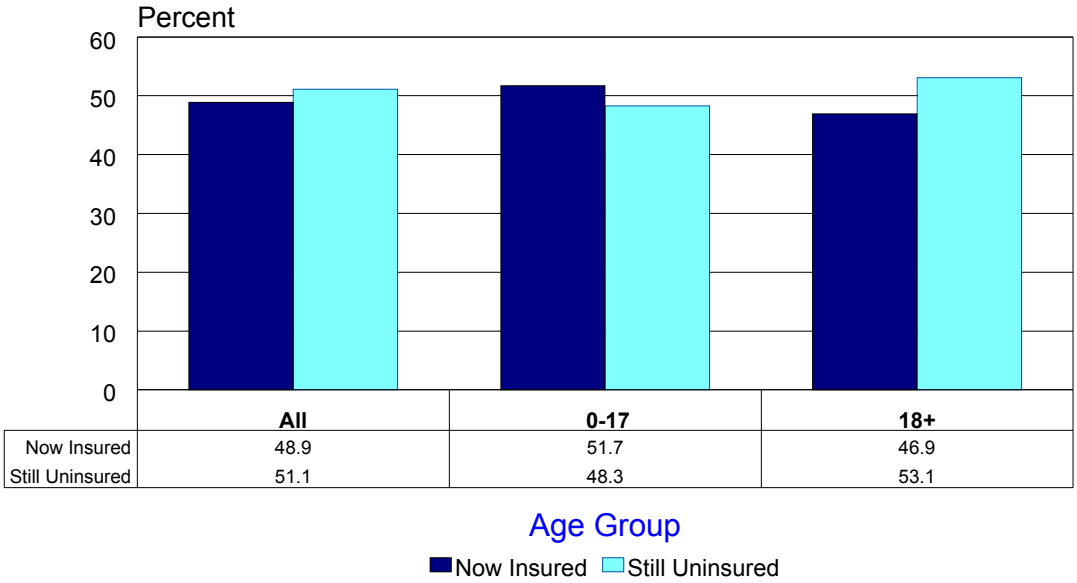
Figure 4-1
Who are the 99,000 Uninsured?

- **74% are over the age of 17**
- **53% are male**
- **68% are white**
- **10% are Hispanic**
- **66% own or are buying their home**
- **15% live alone**
- **80% are above the poverty line**
- **30% have household incomes over $50,000**
- **69% of the adults are single**
- **69% of the adults are working**
- **6% are self-employed**

This list illustrates both the complexity of the task and the need to use targeted strategies. Since 26% of the uninsured are children (which is down significantly since last years report), efforts to increase the coverage of Medicaid, the CHIP program, and the clinics offered by the A. I. DuPont Institute are likely to be effective. There are, however, still likely to be children who may never qualify under Medicaid because their parents are above the income limits and yet may still experience periodic unemployment. It is this population that the CHIP program is designed to help. The effectiveness of the program in covering children will depend significantly on the actions taken by the parent(s) of those children.

Since 69% of the uninsured adults are working at least part-time, legislative initiatives that encourage employer offered health coverage will have some effect. It's not clear at this point in time if any plan can help the low wage earner or part-time employee, since the cost of the insurance might represent a huge increase in labor costs. The working poor, in particular those in the 1.0-1.5 category of poverty, are of particular concern.

Figure 4-2
Percent of Persons who Moved from Uninsured to Insured Status by Age Group



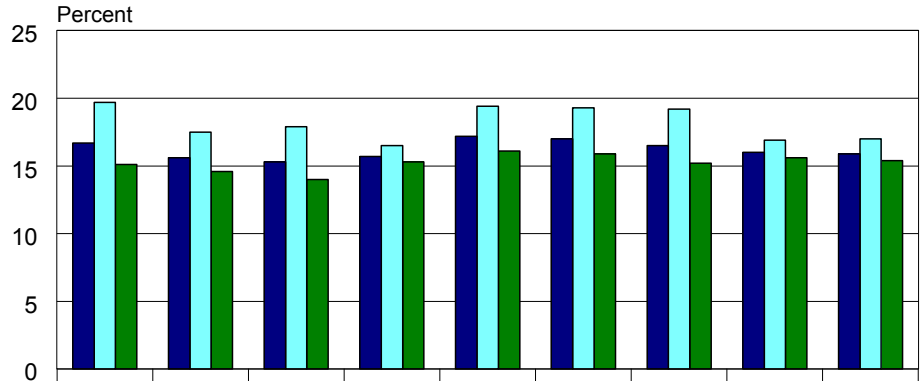
	All	0-17	18+
Now Insured	48.9	51.7	46.9
Still Uninsured	51.1	48.3	53.1

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Dealing with the uninsured is not an easy task because people are continually joining and leaving the ranks of the uninsured (see Figure 4-2, above). Nearly half of those that are uninsured this year (48.9%) will have insurance next year. That proportion is higher for adults than for children.

The problem is not only a question of different rates of movement in and out of the uninsured status. It is also spatially different within the state (see Figures 4-3 and 4-4, below). This may require the execution of very different strategies.

Figure 4-3
Percent of Persons 18-64 Without Health Insurance
by Area



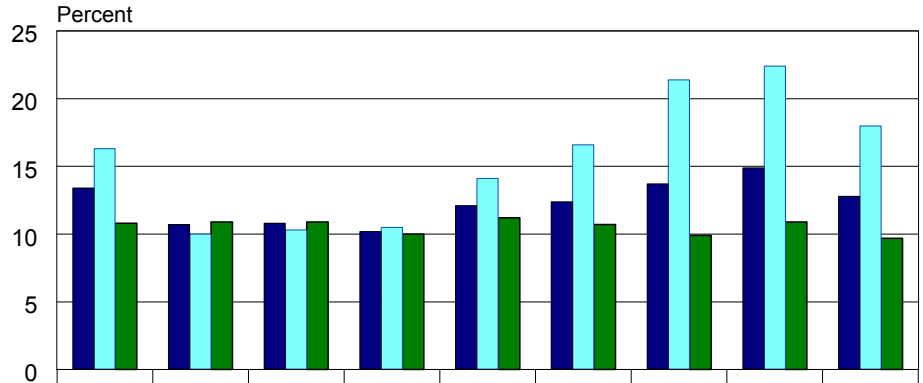
	1992	1993	1994	1995	1996	1997	1998	1999	2000
Delaware	16.7	15.6	15.3	15.7	17.2	17	16.5	16	15.9
Kent+Sussex	19.7	17.5	17.9	16.5	19.4	19.3	19.2	16.9	17
New Castle	15.1	14.6	14	15.3	16.1	15.9	15.2	15.6	15.4

Area

Delaware Kent+Sussex New Castle

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1990-2000

Figure 4-4
Percent of Persons 0-17 Without Health Insurance
by Area



	1992	1993	1994	1995	1996	1997	1998	1999	2000
Delaware	13.4	10.7	10.8	10.2	12.1	12.4	13.7	14.9	12.8
Kent+Sussex	16.3	10	10.3	10.5	14.1	16.6	21.4	22.4	18
New Castle	10.8	10.9	10.9	10	11.2	10.7	9.9	10.9	9.7

Area

Delaware Kent+Sussex New Castle

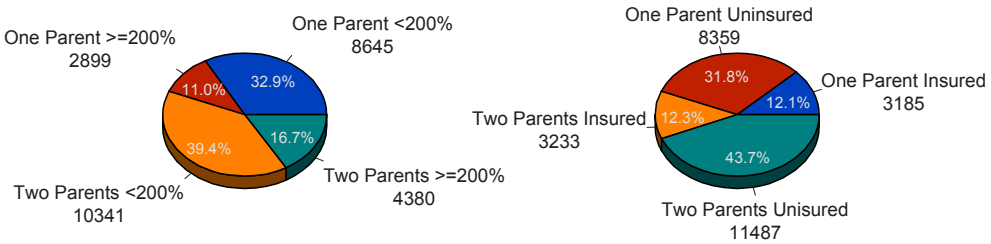
Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1990-2000

First of all, the information provided for the 18-64 year old age group excludes dependents and Medicare recipients. This core group of adults is reasonably stable over the past eight years. Even the differences between the counties are reasonably consistent.

In contrast, the pattern with dependents age 0-17 shown in Figure 4-4 above is strikingly different. While the rates in New Castle County appear stable, those in the combined Kent/Sussex region increased dramatically from 1995 to 1999 and then fell sharply. This is consistent with the implementation of the CHIP program and outreach efforts in lower Delaware. Age and/or geography specific programs are clearly warranted

Overall, Delaware seems to be doing better than the region in keeping the percentage of uninsured down. However, the longer-term demographics of the population and the labor market suggest that this will probably be a continuing challenge. In addition the focus on the CHIP program coupled with identification of Medicaid eligible children is likely to reap significant benefits. It is also clear that there will need to be continued focus on the problems in Kent and Sussex counties if this problem is to be controlled.

Figure 4-5
Persons 0-17 Without Health Insurance
by Family Type, Poverty Status and Parental Insurance

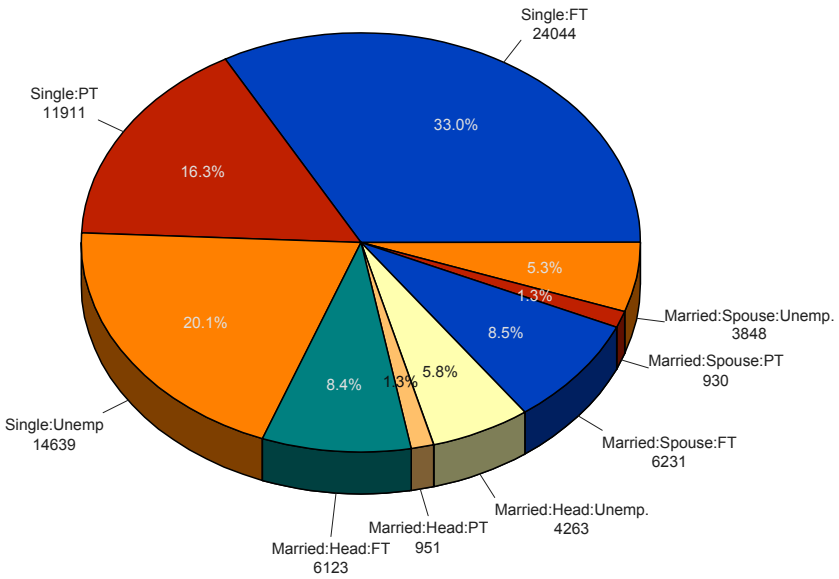


Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1998-2000

Finally, one other useful way of looking at this problem is to divide the uninsured into independent groups, i.e. they do not overlap. There are approximately 26,000 persons under the age of 18 who are uninsured (see Figure 4-5, above). Of the 26,000, some 11,500 can be found in single parent families with 14,500 being in two parent households. Of the 11,500, about 2,900

are above 200% of the poverty level and thus are not currently eligible for CHIP. Of those same 11,500, approximately 8,400 live with parents who also do not have insurance.

Figure 4-6
Persons 18-64 Without Health Insurance
by Marital Status, Household Relationship, and Employment



Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1998-2000

In Figure 4-6, above the 73,000 uninsured adults are displayed by marital status, employment status and household relationship. Almost 70% of the uninsured population is single and they are almost equally split between full-time employment where they might possibility get access to health insurance and an employment status where access to health insurance through an employer is realistically remote. In fact, one could reasonably conclude that only half of the lack of health insurance problem with adults can be approached through employers and that is an outside limit.

APPENDIX B:

DELAWARES SMALL EMPLOYERS: THE HEALTH INSURANCE DILEMMA 2001 REPORT

Delaware's Small Employers: the Health Insurance Dilemma 2001

prepared for
the Delaware Health Care Commission

by

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Highlights of the 2001 Delaware Small Business Survey

- 1601 firms sampled; 725 responses; 550 with insurance and 175 without
- Top three reasons for **Not** offering health insurance: 1) business can't afford it; 2) employees can't afford it; 3) Revenue too uncertain.
- One-third of the firms suggest that the employees have insurance elsewhere or that they are seasonal or part-time workers. The owner has insurance elsewhere 24% of the time.
- Employee recruitment, retention, performance issues related to health insurance are seen as important by less than one fifth of the firms. Businesses that offer health insurance are twice as likely to believe that these issues are important.
- About one-fifth of businesses have previously offered health insurance in the past 5 years and nearly 60% have contacted some provider about insurance in the last year.
- The median firm expects that the total cost of providing health insurance for an employee is about $4800. The actual cost is about $2800.
- Of those that could offer an estimate, the median contribution they would be willing to make was $900 per year and that is less than 20% of the anticipated cost. It is roughly one-third of the cost that small employers tend to pay.
- Government provided assistance would influence about half of these businesses. They would be looking for a 60% contribution. This would require the employee to provide 20% coupled with the 20% the employer is willing to contribute. Remember the employers are overestimating the actual cost of the typical small business.
- On the series of true/false questions about health insurance, business that do not offer health insurance tend to get the right answer 58% of the time. The result for those businesses that offer health insurance was 64%.
- Seventy six percent of the firms without health plans are family owned compared with 57% for those with health plans. Seventy six percent of the owners of businesses that don't have health plans are covered compared with 90% of the owners for firms with insurance having coverage.
- Those businesses without insurance are 3 years younger (12 years in business compared with 15).
- Turnover rates are 24% for those firms without health plans compared with 13% for those with insurance.
- Median full-time employees are 3 for those without insurance and 13 for those with insurance. Median salary for salaried employee is $25,000 compared with $30,000 for those offering insurance. Hourly workers receive $9.00 compared with $10.00 for those who offer health insurance. The median business without insurance has 20% of employees under 30 compared with 17% for those with insurance.
- Forty one percent of businesses that do not offer health insurance think they have either a small obligation or no obligation to do so.

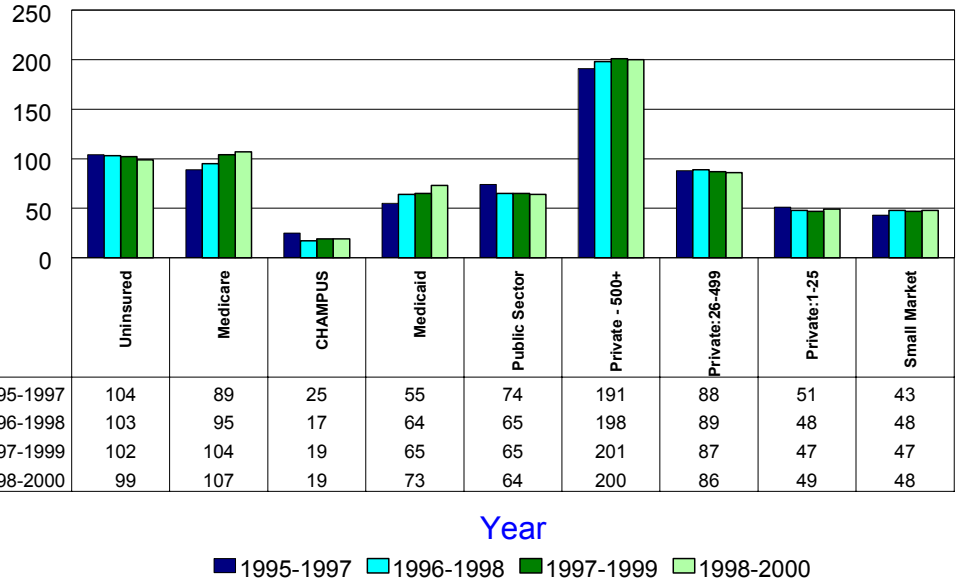
- Half of those that offer insurance also pay something for dependent coverage.
- Roughly a third of the businesses say less than 50% of their employees take the insurance. Roughly a third report participation by 100% of their employees. The median firm suggests that 25% of their employees have some dependent

Introduction

The Delaware Health Care Commission has, since its inception, been concerned about access to health care for all Delawareans. While that is not its only focus, since the Commission's mandate is broad, improving access to health care is a primary goal. Access to health care has several dimensions. One of those dimensions is covered in this report, and that is health insurance coverage. Those with health insurance typically enjoy greater access to health care providers than do those who are without it.

Persons who do not have health insurance are still likely to require medical care at some point in time. When they do require such services, their condition may be significantly worse than had it been detected and addressed at an earlier stage. In addition, the uninsured will tend to use one of the most expensive providers, the emergency room. Ultimately, providers must cover all of their costs. Services delivered to the insured and the uninsured alike, figure into that cost. As a result, some of the cost of services provided to the uninsured is shifted to the insured population. This raises the overall cost of fringe benefits to employers.

Figure 1-1
Number of Persons in Delaware
by Source of Insurance



	Uninsured	Medicare	CHAMPUS	Medicaid	Public Sector	Private - 500+	Private:26-499	Private:1-25	Small Market
1995-1997	104	89	25	55	74	191	88	51	43
1996-1998	103	95	17	64	65	198	89	48	48
1997-1999	102	104	19	65	65	201	87	47	47
1998-2000	99	107	19	73	64	200	86	49	48

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census Current Population Survey, March 1995-2000

To better understand the nature of the uninsured population, the Delaware Health Care Commission has been monitoring its size and structure for a number of years. This report adds to the depth of this information and analysis by focusing on the small employers of the state. Most Delawareans, who are not covered by one of the government programs, are dependent on their employers for health insurance (see Figure 1-1, above). Unfortunately, the capacity for employers to provide this coverage and for employees to pay their share is uneven. This is particularly true for employers with fewer than 50 employees and for employers who have low wage and/or part-time employees.

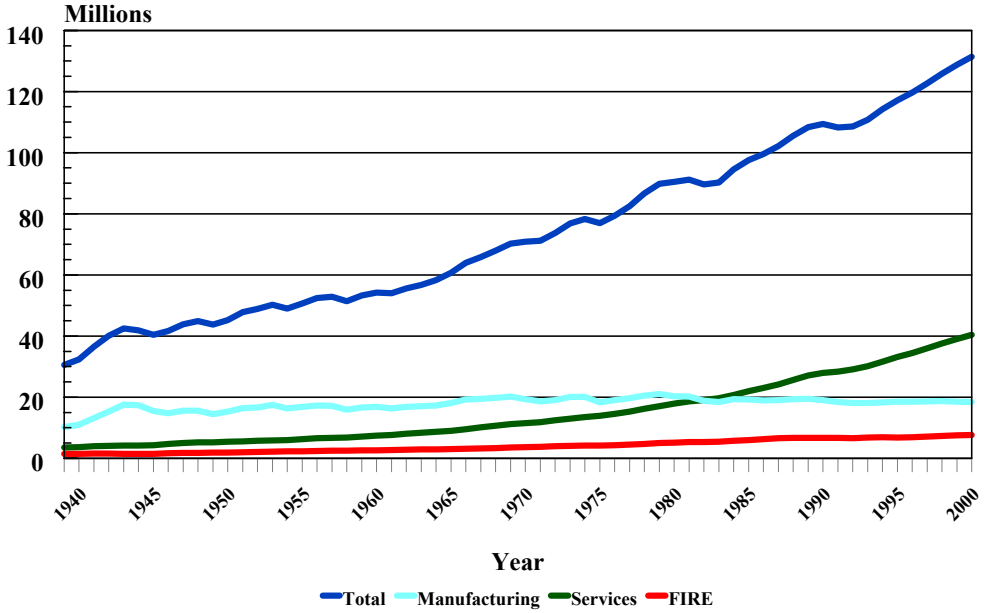
The report has four major sections. In the first section, the focus is on the labor market in Delaware and on existing and future trends that might affect employer provided health coverage. The second section contains results from the employer survey conducted this year that focuses on the variables that are correlated with not having a health plan. This survey draws heavily on the instrumentation used in the "2000 Small Employer Health Benefits Survey", which was co-sponsored by the Blue Cross and Blue Shield Association, the Employee Benefit Research Institute, and the Consumer Health Education Council. The third section focuses on firms that do not have health plans. Observations about these trends and responses are provided in the last section.

The Labor Market

Background

Health care coverage is inexorably linked to an individual's employment status along with the type and size of firm for which they work. Many Delawareans have recently experienced more instability in their labor market activity and this has, inevitably, affected aspects of their coverage. The factors producing this increased instability are varied and are both national and international in scope. There are, however, some basic trends that are important to understand since they are affecting and will continue to affect health care coverage in the years to come.

Figure 2-1
US Non-Agricultural Employment:
Selected Sectors 1939-2000

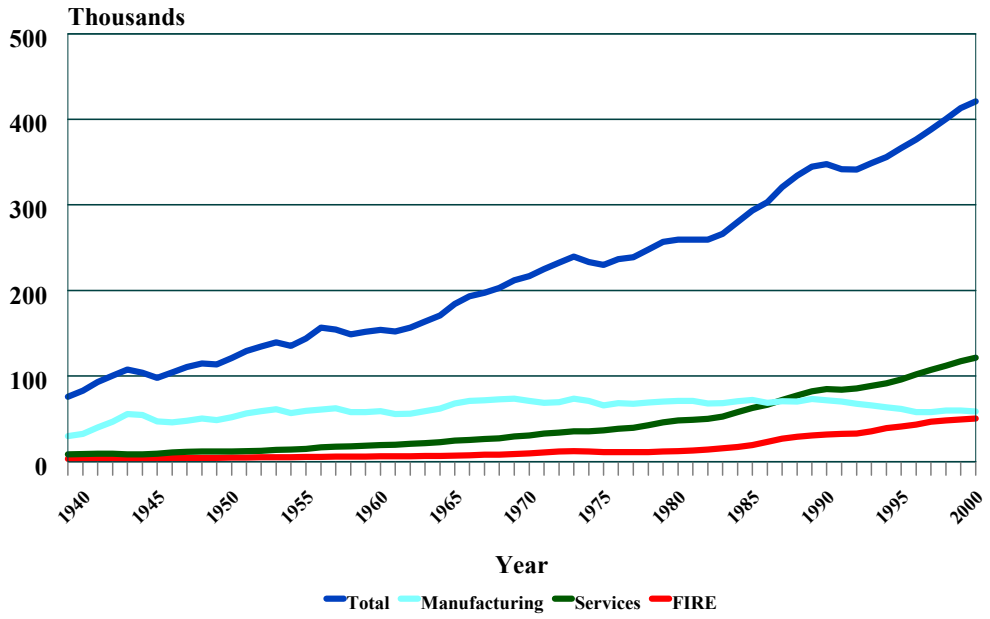


Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Labor Statistics

In Figure 2-1 above, the total employment for the United States from 1939 through 2000 is shown along with three of the ten employment sectors namely: manufacturing, services, and FIRE (finance, insurance, and real estate). The graph clearly shows the impact that the business cycle has had on total employment in the mid-1970s, the early 1980s, and the early 1990s. All of these economic events are associated with rapid increases in the percentage of persons without health coverage. The more subtle influence is related to the change in the structure of

employment. Manufacturing employment reached its peak in the late 1970s and has been in a steady but very shallow decline for the most part. Service industry employment increased steadily over the entire period and began accelerating its growth when manufacturing employment was at its peak. In 1981, service sector employment surpassed manufacturing employment and today it accounts for nearly twice as much employment as manufacturing. This trend will probably continue unabated for the foreseeable future.

Figure 2-2
Delaware Non-Agricultural Employment:
Selected Sectors 1939-2000

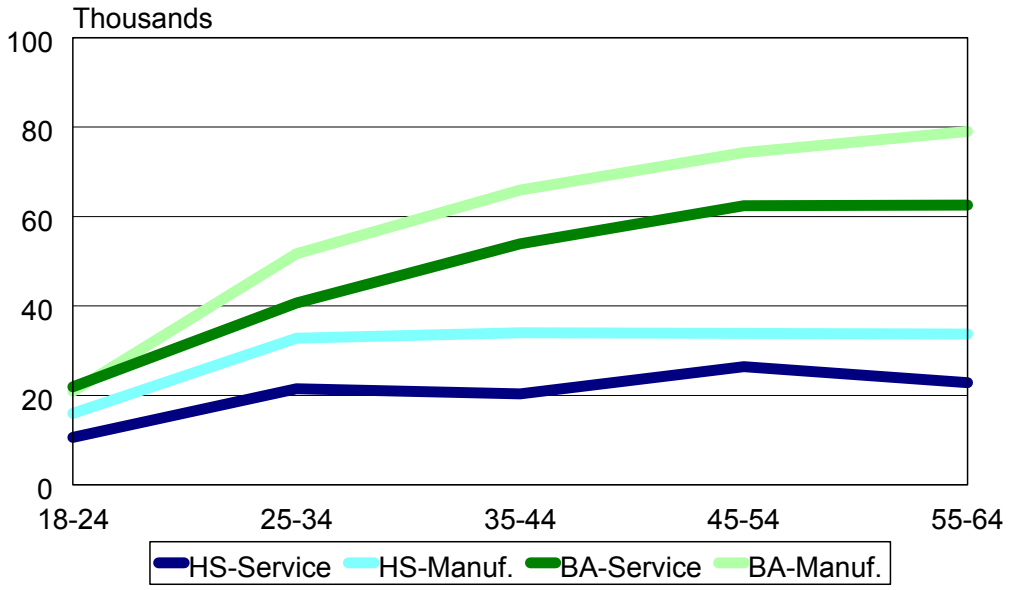


Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Labor Statistics, Delaware Department of Labor

The pattern was similar in Delaware, although the recession of the mid-1970s was more severe and the later ones were perhaps less damaging than they had been nationwide. For instance, statewide manufacturing employment peaked during 1989. This marked the end of the expansion of the 1980s. Since then, the number of manufacturing jobs available to Delawareans has dropped significantly and continues to fall even today. In 1986, four years after it happened nationally, statewide service industry employment surpassed manufacturing employment. The rate of growth in service sector employment in recent years has slowed somewhat compared with the rate for the U.S. but this has been offset by the incredible growth in the FIRE sector.

Employment in the FIRE sector clearly exploded after the passage of the Financial Center Development Act in the early 1980s. It continued to grow dramatically until the 1990-1991 recession. To most observers' surprise, the growth re-ignited in 1992 and continues today. A comparison of the trends in Figure 2-1 and Figure 2-2 show this to be a Delaware phenomenon.

Figure 2-3
Average Annual Earnings by
Sector, Age, and Education in 1998-2000



Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census Current Population Survey, March 2000

The importance of these inter-sector employment shifts is shown in Figure 2-3 above. Figure 2-3 shows the average annual earnings by age, education, and industrial sector. The top two lines represent annual earnings for college graduates in the manufacturing and service sector respectively. The bottom two lines depict the same information for high school graduates in the same two sectors.

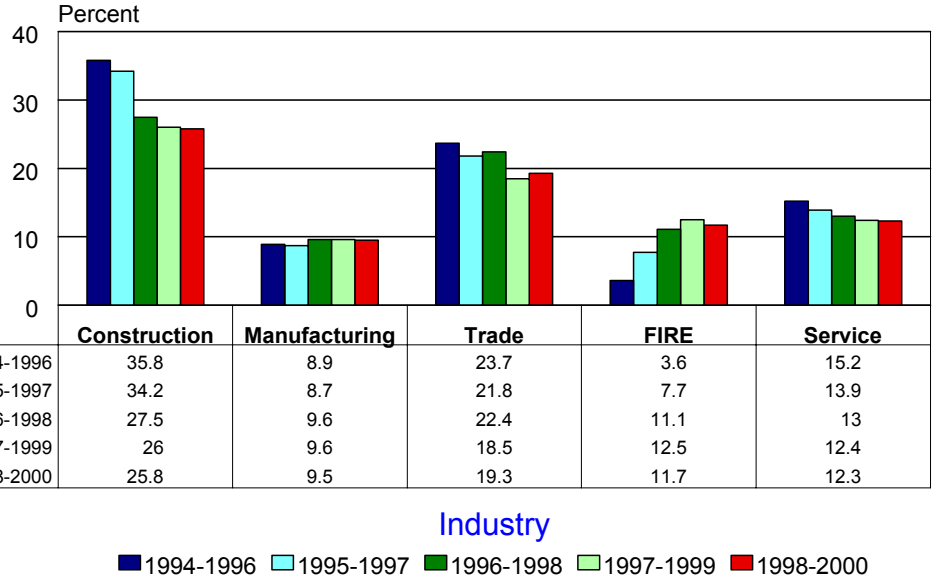
The graph shows a difference of about $40,000 in annual earnings between the two sectors for both levels of education. If the same health care benefits were offered in both sectors, the cost to employers would be a much larger proportion of the annual salary in the service sector than in manufacturing. This suggests that employees in the service sector will likely be offered fewer benefits.

In addition, those employed in manufacturing are much more likely to be represented in a collective bargaining unit, a union. They are also more likely to work full-time with significant overtime, which further reduces the impact of the cost of benefits on total compensation. In contrast, service sector workers are more likely to be employed by non-union companies and are much more likely to work part-time. These factors, coupled with the increasing number of service sector workers relative to the number of manufacturing workers will tend to increase the number of uninsured or under-insured people.

Firm Sector and Size

There are significant differences in both the level and pattern of the uninsured, depending upon the type of industry in which an individual is employed. For instance, according to Figure 2-4 below, construction workers frequently report being uninsured. Although it may be noted that some construction workers are unionized, and are usually provided health coverage, many more are either employed by a non-union company or are self-employed. Overall, it is estimated that more than 25% of all construction workers are uninsured.

Figure 2-4
Percent of Persons without Health Insurance in Delaware by Industrial Sector



	Construction	Manufacturing	Trade	FIRE	Service
1994-1996	35.8	8.9	23.7	3.6	15.2
1995-1997	34.2	8.7	21.8	7.7	13.9
1996-1998	27.5	9.6	22.4	11.1	13
1997-1999	26	9.6	18.5	12.5	12.4
1998-2000	25.8	9.5	19.3	11.7	12.3

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Many persons employed in the trade industry (retail and wholesale) also find themselves without health coverage. Because this sector is not heavily unionized and is reliant on a large number of part-time workers (most of whom do not qualify for a typical health insurance

package), it is not unexpected that an estimated 19% of those employed in the trade industry currently lack health coverage. The most recent data suggests that the upward trend operating since 1994 has moderated.

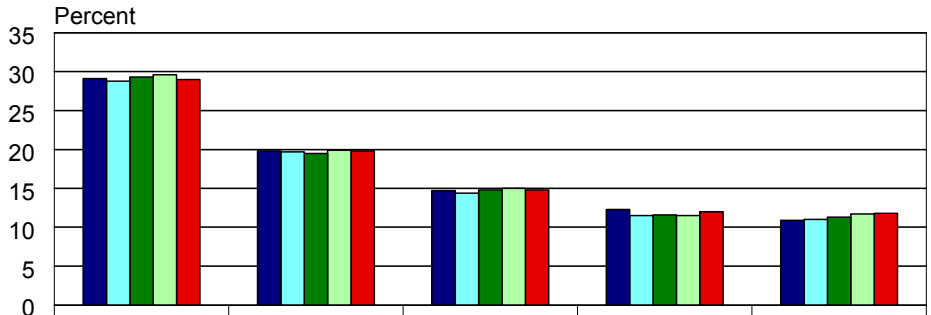
Of the other industries represented in Figure 2-4, approximately 12% of all those employed in the service industry are not offered access to health insurance as part of a benefits package. This number appears to be declining somewhat over the period. This probably reflects the changing nature of the service industry.

Roughly 10% of those employed in manufacturing and FIRE do not have health coverage. However, the proportion uninsured in the FIRE sector appears to be increasing. This could, for example, reflect an increase in full-time temporary employees in this sector

Finally, it also should be pointed out that the differences in coverage between industries are among the largest observed for any variable in this report. The importance of this information relates to the changing structure of the economy. As employment shifts from manufacturing to the service sector, the percentage of uninsured workers increases by about 3%. The importance of the FIRE sector in Delaware cannot be over estimated at least with respect to health coverage, although the 2000 estimates make this conclusion less clear. While the percentage of uninsured in the region has been rising, Delaware's rate has either been falling or remaining steady. This appears, in large part, to be related to the accelerating FIRE sector and to a less rapidly growing service sector.

The other important inter-sector shift, which is more subtle, is associated with the nature of downsizing in Delaware's manufacturing sector. A significant portion of those employees who were "downsized" belonged to headquarters support operations as opposed to the factory floor. In many cases, those same employees started or joined firms that supplied services to their previous employer who simply wanted to "out-source" those functions. Many of these new jobs are classified as business services, part of the service sector, and are far from the typical "hamburger flipper" often discussed in the media. This has produced increases in annual earnings in the service sector that bodes well for benefit programs in the future.

Figure 2-5
Percent of Persons without Health Insurance in the US
by Size of Firm



	Under 25	25-99	100-499	500-999	1000+
1994-1996	29.1	19.8	14.7	12.3	10.9
1995-1997	28.8	19.7	14.4	11.5	11
1996-1998	29.3	19.5	14.8	11.6	11.3
1997-1999	29.6	19.9	15	11.5	11.7
1998-2000	29	19.8	14.8	12	11.8

Size of Firm

1994-1996 1995-1997 1996-1998 1997-1999 1998-2000

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

Employees who work for small firms (under 100 employees) are less likely to have health insurance than those that work for large firms (more than 500 employees). Figure 2-5 above shows this relationship.

The graph shows that there are two distinct groupings: (1) firms with less than 100 employees where the percentage without health insurance is 24% and (2) firms with more than 500 employees where the percentage of those without health insurance is 12%. The larger firms are perhaps more likely to be unionized at least to the extent that larger firms have a higher probability of being in sectors such as manufacturing. They are also more likely to pay higher wages, which makes the relative cost of health insurance more tolerable. From a tax perspective, the provision of health insurance also provides a convenient way to increase total compensation.

A somewhat disturbing trend is also evident in Figure 2-5. It appears, at least from the national perspective, that those working for smallest firms are not improving their insurance coverage in comparison with five years ago. What makes this trend so disconcerting is the fact that the economy has been expanding for almost ten years. The same can be said for larger firms, however. One explanation for this lack of improvement is the lack of increases in wages

nationally and the restructuring and cost cutting practiced by most firms, which has produced significant increases in earnings.

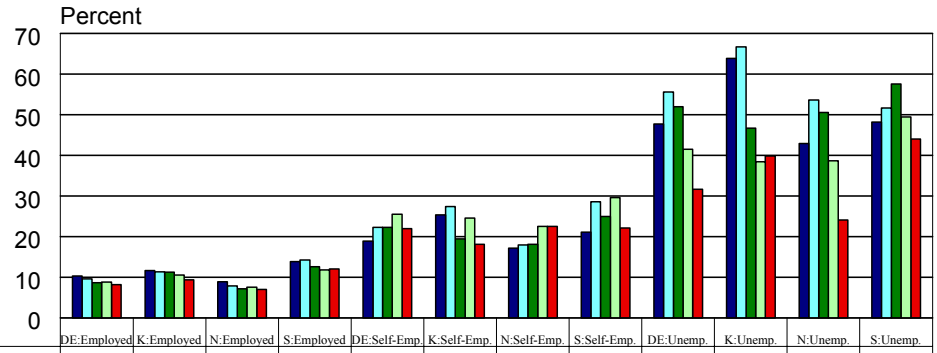
In conclusion, these data suggest that any effort to increase coverage must focus on smaller firms. Those firms will tend to provide lower levels of compensation, will probably use more part-time employees, and may offer less stable employment. However, they are growing faster and becoming a bigger part of the economy. This fact may tend to mitigate some of the negative factors over time. On the other hand, the large firms with better coverage are becoming smaller and that does not help the long-term outlook. There is no doubt, however, that all of these factors will tend to make the goal of better access to health care a challenge for the foreseeable future.

Employment Status and Class

Approximately 75% of all Delawareans are covered by some form of group health insurance. The vast majority is covered through their employer and therefore any disruption in employment will undoubtedly increase the likelihood that coverage will lapse. The reason that coverage may not automatically lapse is because that individual may be covered by another worker in the family, or the coverage may be extended through payments by the employee, or the individual may qualify for some government sponsored plan like Medicaid or Medicare. Still, the disruption is significant as is shown in Figure 2-6, below.

The information reported in Figure 2-6 shows that the probability of being without heath insurance increases by nearly a factor of four when the individual is unemployed. The percentage on the average rises from about 8% to in the vicinity of 32% as the individual's employment status changes. There is considerably more volatility in the estimates in Kent and Sussex counties because of small sample sizes, but the relationship mirrors that in New Castle County where sample size is not a problem. While those that are self-employed are also found in relatively small numbers in the BRFSS survey, the lack of health insurance is at least twice as prevalent as that of those with traditional employment. This year there is little observable difference between the counties with respect to the self-employed.

Figure 2-6
Percent of Adults without Health Insurance in Delaware
by County and Employment Status



	DE:Employed	K:Employed	N:Employed	S:Employed	DE:Self-Emp.	K:Self-Emp.	N:Self-Emp.	S:Self-Emp.	DE:Unemp.	K:Unemp.	N:Unemp.	S:Unemp.
1994-1996	10.3	11.7	8.9	13.9	18.9	25.4	17.2	21.1	47.7	63.9	42.9	48.2
1995-1997	9.6	11.4	7.9	14.3	22.3	27.4	18	28.6	55.6	66.7	53.6	51.7
1996-1998	8.7	11.3	7.2	12.6	22.3	19.5	18.1	25	52	46.7	50.6	57.6
1997-1999	8.8	10.6	7.6	11.8	25.5	24.6	22.5	29.6	41.5	38.4	38.7	49.5
1998-2000	8.2	9.4	7	12.1	22	18.1	22.5	22.1	31.7	39.9	24.1	44

Employment Status by County

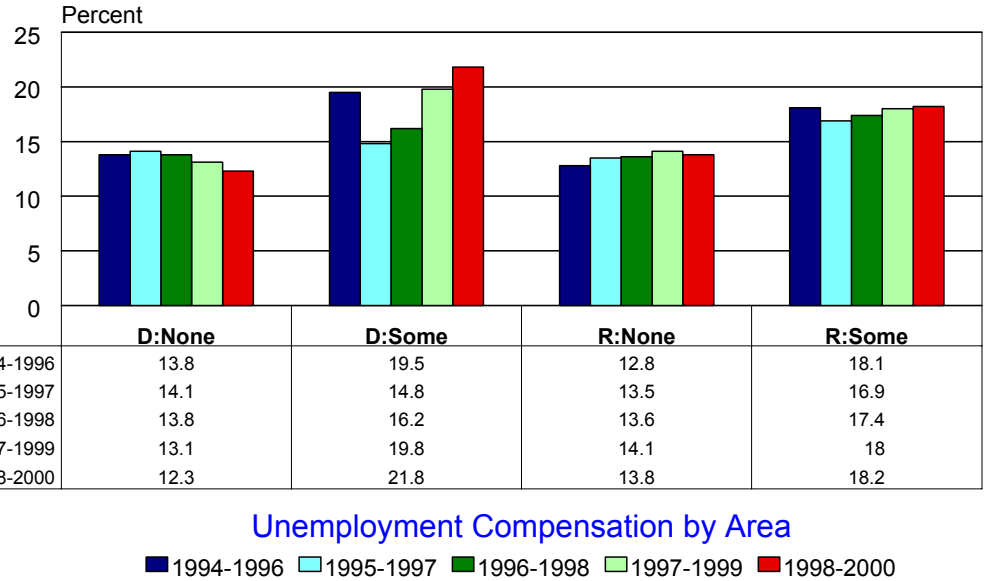
1994-1996 1995-1997 1996-1998 1997-1999 1998-2000

Source: Center for Applied Demography and Survey Research, University of Delaware
Delaware Health and Social Services, 1994-2000 Behavioral Risk Factor Survey

The other piece of information that deserves comment is the relative differences between the lack of coverage for employed workers in the three counties. The rate in New Castle County is significantly lower than those observed in Kent and Sussex counties. Following the earlier argument, this probably arises from differences in the economic base, since larger firms with higher wages and more stable employment are located primarily in the northern part of the state.

In Figure 2-7 below, further evidence is found about the relationship between insurance coverage and employment status. In this analysis, the receipt of unemployment compensation is used as an indicator of an interruption of employment at some point during the year. In both Delaware and the region, there is a significant rise in the lack of health coverage associated with receiving benefits. While the effect is more muted than in Figure 2-6, where a more direct measure was available, the percentage is always higher in the region where the sample size permits a better estimate.

Figure 2-7
Percent of Persons without Health Insurance
by Receipt of Unemployment Compensation and Area



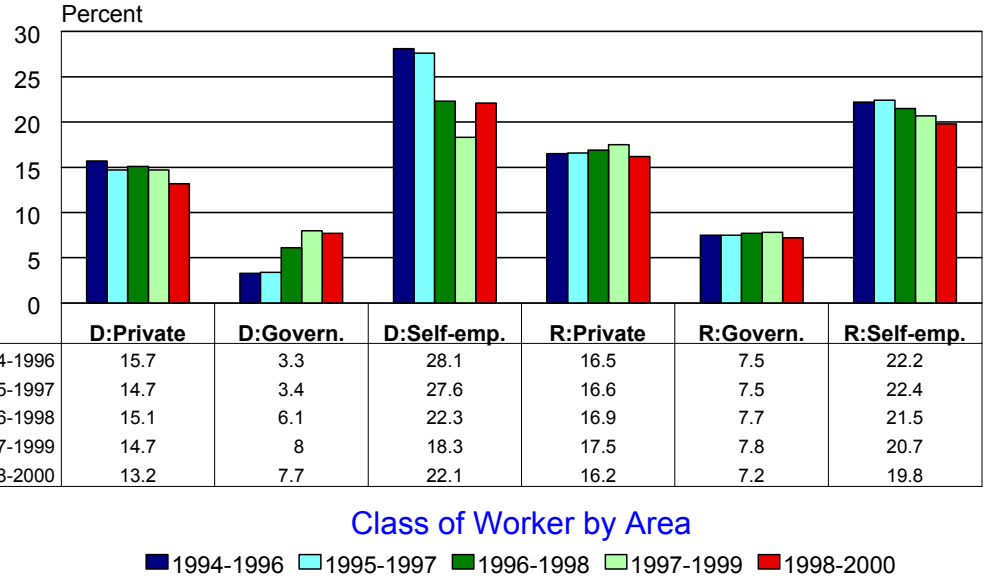
	D:None	D:Some	R:None	R:Some
1994-1996	13.8	19.5	12.8	18.1
1995-1997	14.1	14.8	13.5	16.9
1996-1998	13.8	16.2	13.6	17.4
1997-1999	13.1	19.8	14.1	18
1998-2000	12.3	21.8	13.8	18.2

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

The final graph in this section of the report represents the percentage of workers without health insurance in Delaware and the region as indicated by three broad classes namely: private sector workers, government workers, and the self-employed. In Figure 2-8 below, Delaware workers in the private sector average 3% fewer uninsured than those in the region. Within the private sector, Delaware seems to be improving slightly over the time period, which is consistent with the increase in workers in the FIRE sector. The rates in the region, for the private sector, are increasing, which probably reflects increases in the service sector and in part-time employees. Both trends should be watched carefully.

It is no surprise that government employees both in Delaware and the region are far more likely to have health insurance than the private sector in general. Government rates are comparable with very large private sector firms operating in a unionized work place. The only government workers who are likely to lack coverage are temporary/part-time workers or private contractors.

Figure 2-8
Percent of Persons without Health Insurance
by Class of Worker and Area



	D:Private	D:Govern.	D:Self-emp.	R:Private	R:Govern.	R:Self-emp.
1994-1996	15.7	3.3	28.1	16.5	7.5	22.2
1995-1997	14.7	3.4	27.6	16.6	7.5	22.4
1996-1998	15.1	6.1	22.3	16.9	7.7	21.5
1997-1999	14.7	8	18.3	17.5	7.8	20.7
1998-2000	13.2	7.7	22.1	16.2	7.2	19.8

Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1994-2000

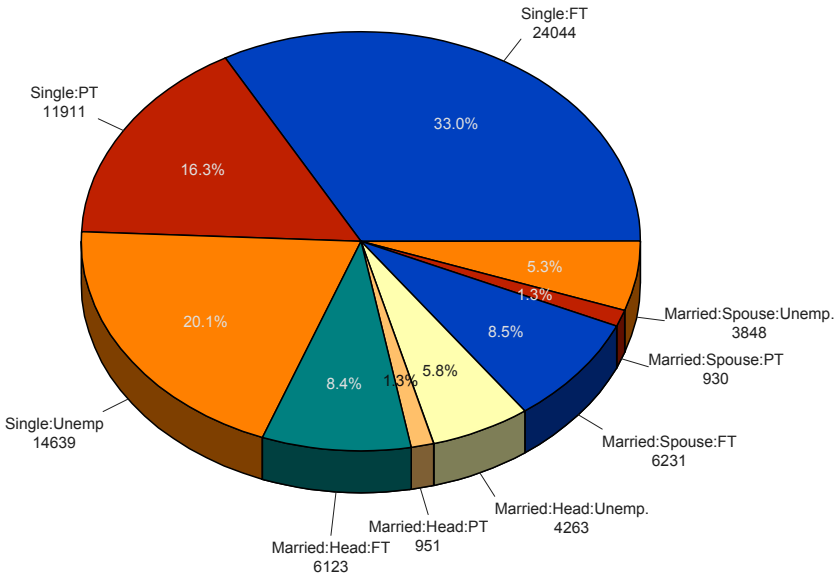
A more interesting structural shift, which has been underway for some time, is that government workers are representing a smaller proportion of the labor force, since that sector is growing less rapidly than employment overall. This implies that the percentage of uninsured workers will tend to rise, even if all the rates within these classes remain constant.

The information about the self-employed corroborates the information from the BRFSS discussed earlier. The data for the region, however, shows that the significant upward trend previously identified has moderated. There are a variety of potential explanations. One reason, which is consistent with other data, is that tight labor markets have allowed many of those previously classified as "self-employed" to find work and to gain benefits. Those that remain self-employed are likely to be financially stronger and better able to obtain health insurance.

Finally, one other useful way of looking at this problem is to divide the uninsured into independent groups, i.e. they do not overlap. There are approximately 26,000 persons under the age of 18 who are uninsured. In Figure 2-9, below the 73,000 uninsured adults are displayed by marital status, employment status and household relationship. Almost 70% of the uninsured population is single and they are almost equally split between full-time employment where they might possibility get access to health insurance and an employment status where access to health

insurance through an employer is realistically remote. In fact, one could reasonably conclude that only half of the lack of health insurance problem with adults can be approached through employers and that is an outside limit.

Figure 2-9
Persons 18-64 Without Health Insurance
by Marital Status, Household Relationship, and Employment



Source: Center for Applied Demography and Survey Research, University of Delaware
US Bureau of Census, Current Population Survey, March 1998-2000

Health Plan Status

Background

In the previous section, clear evidence was presented that suggested that small employers required special study if the number of uninsured was to be reduced. The proportion of those uninsured who were working for employers with 25 or fewer employees was 2.5 times the rate found in Delaware's largest employers (29% compared with 11.8%). In addition, about half of those who are currently uninsured are working full-time, and many of those work for small employers. This information led to the conclusion that any potential solution to the problems of the uninsured must address the situation faced by small employers. The result of that observation was the design, execution, and analysis of a survey of this group of employers.

Using a database supplied by the Delaware Department of Labor, some 12,875 firms with between 2 and 50 employees were identified. Together they comprised 92% of the firms with more than a single employee. Single employee firms were judged to be special cases since they included only the firm owner in most cases and were excluded from the study.

The study used a disproportionate stratified sample design with four strata, namely 1) less than 6 employees, 2) 6 to 15 employees, 3) 16 to 25 employees, and 4) 26 to 50 employees. The sample was drawn to produce equal numbers of firms in each strata. While this makes the analysis more complex, it satisfied the need to do analysis between the groups as well as for the overall sample.

Each employer received an initial letter from the Delaware Healthcare Commission explaining the purpose of the study set to arrive several days before the actual survey instrument. Two survey instruments were mailed out asking employers to fill out the green survey if they offered insurance and a different survey colored red if they did not. If a response was not received within a week a reminder post card was sent, followed by a second copy of the questionnaire. This too was followed by another reminder card and a third survey.

Of the 1601 surveys that were mailed, 725 were returned at the completion of the protocol yielding an overall response rate of 45.3%. The response rates for the four strata were similar namely, 1) 45.4%, 2) 39.2%, 3) 48.9%, and 4) 45.7%. While these levels are not

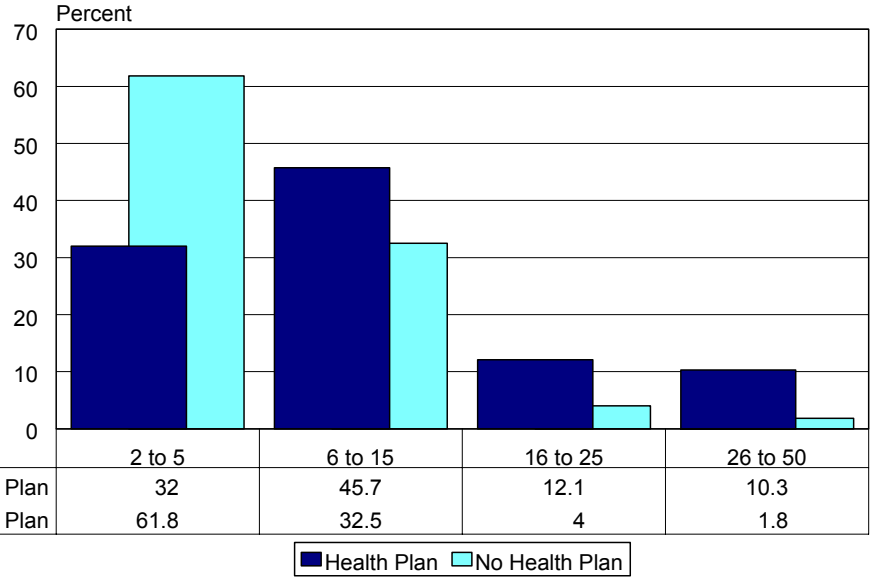
sufficient to suggest that the potential for non-response bias is minimal, they are significantly higher levels than typically are found in business surveys. This is at least consistent with the hypothesis that the problem of health insurance is a matter of concern to this particular group of employers.

Health Plan Status

A number of factors affect the decision to offer health insurance coverage to employees and many of those factors are directly related to the nature and structure of the business the employer is conducting. In this section, a series of those factors will be addressed with respect to two different relationships between the variable and the business's health coverage status.

Size of firm in terms of the number of employees is important, as was noted in the first part of this report where significant differences were noted in health coverage for employees working for firms of different sizes. In Figure 3-1 below, the distribution of employers within each health coverage status is displayed.

Figure 3-1
Number of Employees
by Firm Health Plan Status



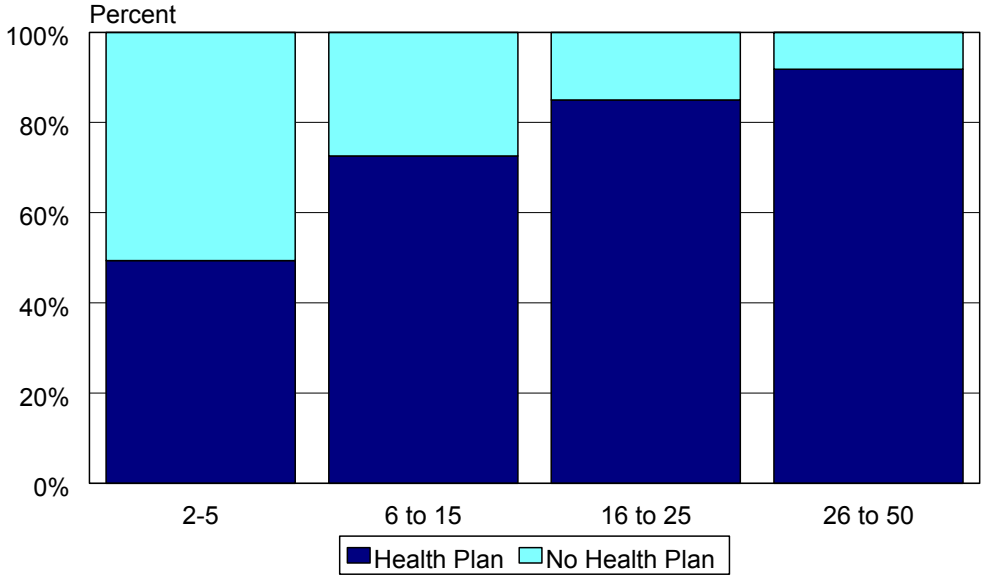
	2 to 5	6 to 15	16 to 25	26 to 50
Health Plan	32	45.7	12.1	10.3
No Health Plan	61.8	32.5	4	1.8

Source: Center for Applied Demography and Survey Research, University of Delaware

It is hardly unexpected that firms that do not offer health insurance are disproportionately concentrated in the smallest employee category with a proportion that is

nearly twice that of those who offer coverage. The overall relationship is even clearer showing the probability of providing coverage within each size classification (see Figure 3-2, below).

Figure 3-2
Firm Health Plan Status
by Number of Employees



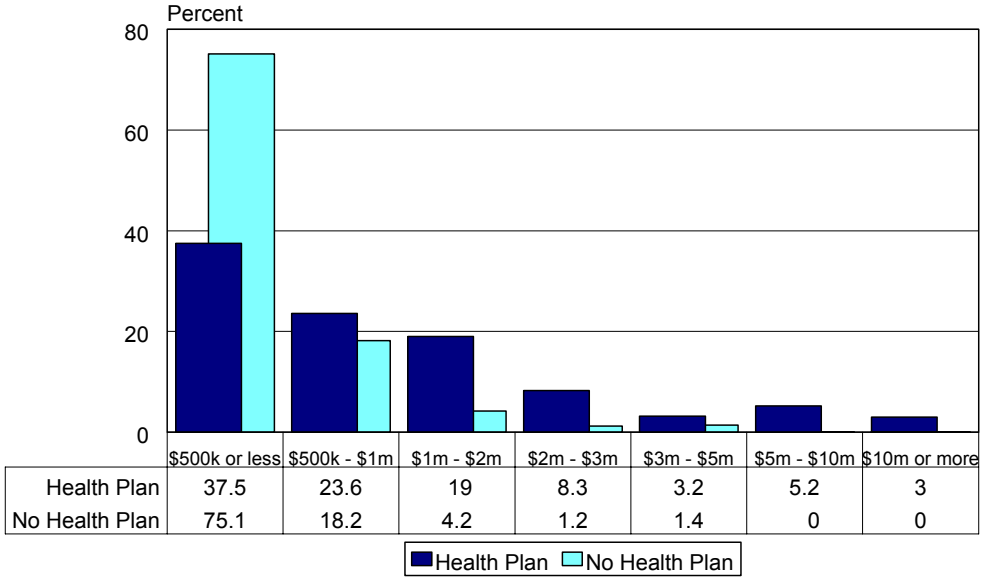
Source: Center for Applied Demography and Survey Research, University of Delaware

The chart shows that the proportion of firms offering health insurance increases as the number of employees increases. It is instructive to see that nearly 50% of the firms even in the smallest size category offer coverage. Obviously there is significant variation in the profitability and stability independent of size in order to afford this benefit. There are substantial differences between a small accounting firm with full-time professionals and a small retail firm with part-time low wage employees.

There is more than one measure of economic size. Gross revenue is quite often used as a measure to complement the number of employees. The results with health plan status are much more pronounced than the earlier chart by number of employees (see Figure 3-3, below). Firms that do not offer plans are even more concentrated in the smallest revenue category and are totally absent in the two largest categories.

The distribution within revenue class is shown in Figure 3-4, below. A smaller proportion of firms within the smallest revenue class offer health insurance compared with the smallest employee class. Clearly, health insurance coverage increases as revenue increases.

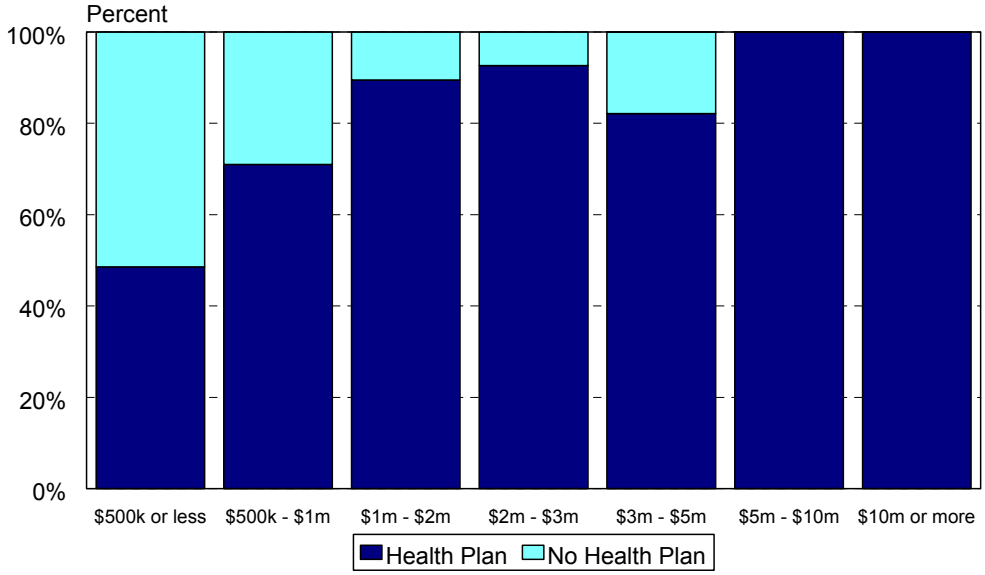
Figure 3-3
Revenue Class
by Firm Health Plan Status



	$500k or less	$500k - $1m	$1m - $2m	$2m - $3m	$3m - $5m	$5m - $10m	$10m or more
Health Plan	37.5	23.6	19	8.3	3.2	5.2	3
No Health Plan	75.1	18.2	4.2	1.2	1.4	0	0

Source: Center for Applied Demography and Survey Research, University of Delaware

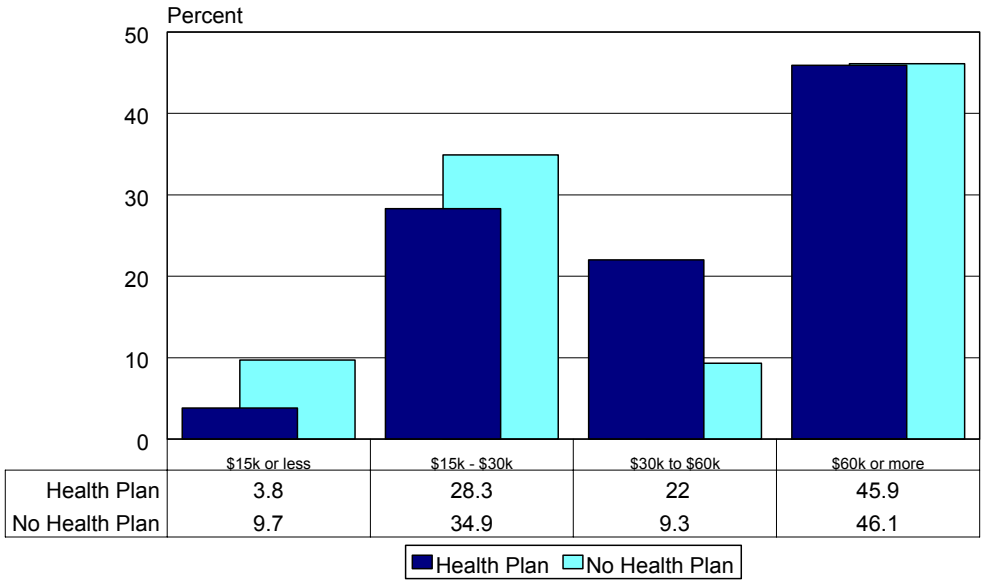
Figure 3-4
Firm Health Plan Status
by Revenue Class



Source: Center for Applied Demography and Survey Research, University of Delaware

The ability of the employee to share in the cost of health insurance coverage and the willingness of the employer to contribute depends at least to some degree on the amount the typical employee is being paid. The larger the wage, the easier it is for the employee to contribute. As the wage increases, health insurance costs become a smaller share of total employment costs.

Figure 3-5
Full-time Employee Salary Class
by Firm Health Plan Status



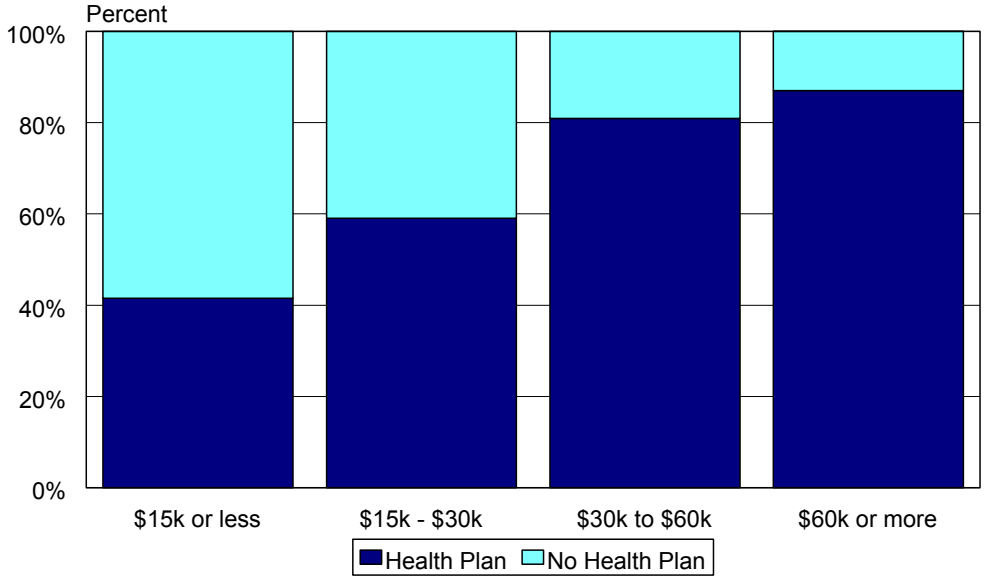
	$15k or less	$15k - $30k	$30k to $60k	$60k or more
Health Plan	3.8	28.3	22	45.9
No Health Plan	9.7	34.9	9.3	46.1

Source: Center for Applied Demography and Survey Research, University of Delaware

Figure 3-5, above, shows the distribution of firms within health plan status across categories depicting the typical salary of a full-time worker in the firm. In contrast to many of the other charts, there is no clear pattern. In fact, both categories of firms have almost identical representation in the highest salary category.

A much clearer view emerges when one looks within each salary category. That result is found in Figure 3-6, below. In this chart the positive relationship between salary levels and the availability of a health plan is readily apparent. Over that range the ratio of total health insurance cost to the typical individual's salary falls from 19% to under 5%. In addition, the tax benefit even further expands the difference.

Figure 3-6
Firm Health Plan Status
by Full-time Employee Salary Class

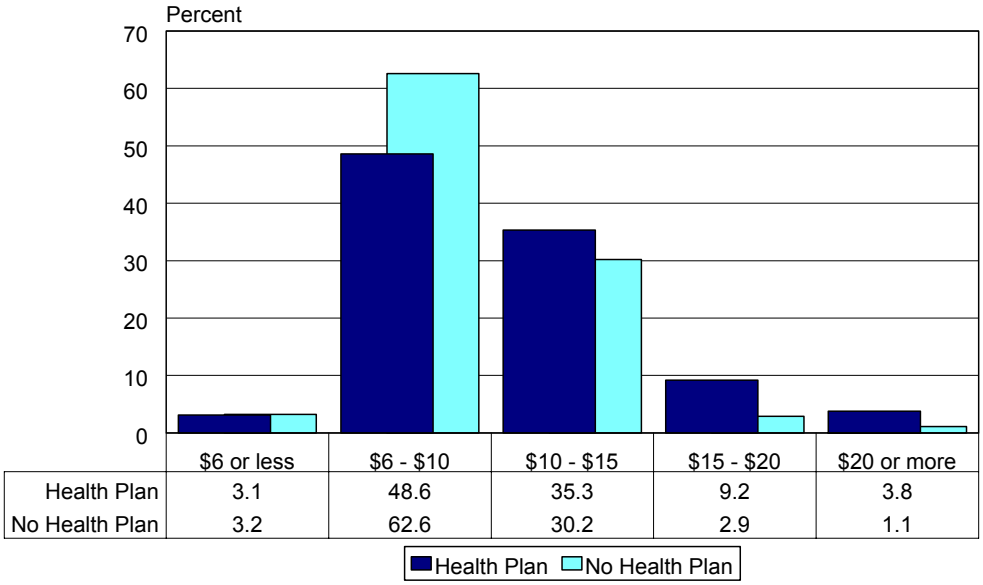


Source: Center for Applied Demography and Survey Research, University of Delaware

Since a significant proportion of the labor force receives an hourly pay rate as opposed to an annual salary, respondents were asked about the typical hourly wage rate as well. The pattern is quite similar to that observed for the annual salary data. Both sets of firms are distributed similarly across the wage spectrum. If anything, firms that do not offer health insurance tend to more frequently report paying wages under $10 per hour and there are very few of those firms that pay more than $15 per hour. This can be seen in Figure 3-7 below.

In Figure 3-8, below, the relationship between offering a health plan and typical hourly wage is even clearer. Instead of the rather nice rising relationship between annual salary and health coverage, there appears to be a threshold effect operating at $15 per hour. Below that wage, the probability of the firm offering health insurance is reasonably stable. After that point, which is the equivalent of $30,000 per year at full-employment, there is a substantial increase in the probability of offering insurance. That level is similar to what was observed for salaried workers in the $30,000 to $60,000 salary class.

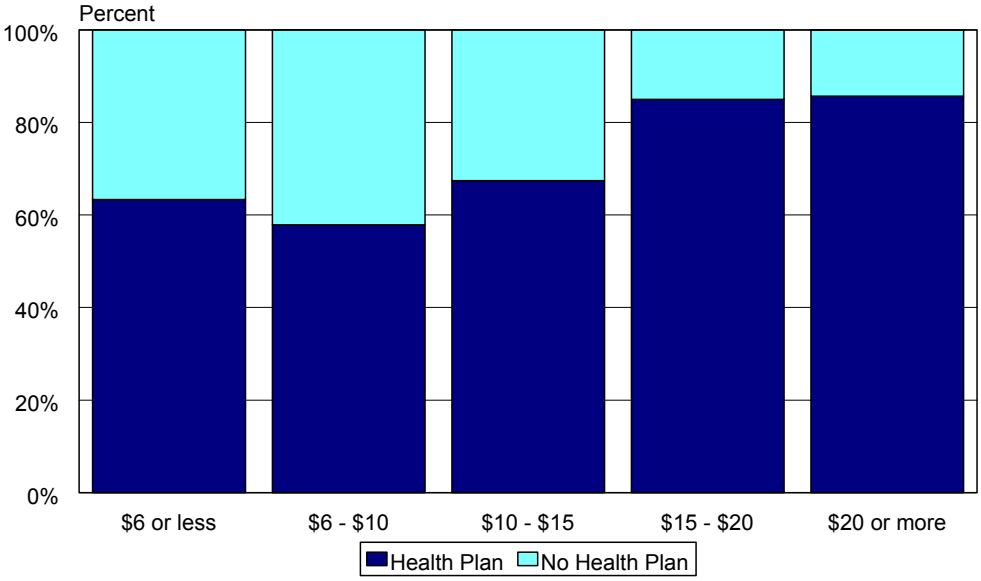
Figure 3-7
Typical Hourly Wage
by Firm Health Plan Status



	$6 or less	$6 - $10	$10 - $15	$15 - $20	$20 or more
Health Plan	3.1	48.6	35.3	9.2	3.8
No Health Plan	3.2	62.6	30.2	2.9	1.1

Source: Center for Applied Demography and Survey Research, University of Delaware

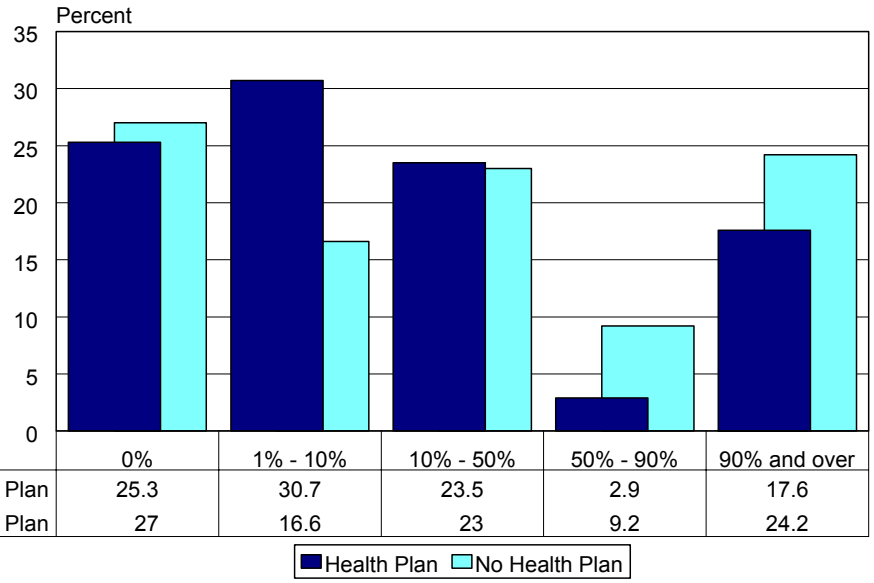
Figure 3-8
Firm Health Plan Status
by Typical Hourly Wage



Source: Center for Applied Demography and Survey Research, University of Delaware

The relationship between turnover rates and the willingness of an employer to offer health coverage is complex. Turnover is in part defined by the tightness of the labor markets where employees continually try to improve their income level, benefit offering or working conditions. An employer will be very sensitive if there are significant training costs associated with new employees. If these costs are low relative to the wages paid, then turnover becomes the norm. Offering health insurance coverage will probably add to employment costs without corresponding productivity. The turnover rates for the two sets of firms are shown in Figure 3-9, below.

Figure 3-9
Turnover Rates
by Firm Health Plan Status



	0%	1% - 10%	10% - 50%	50% - 90%	90% and over
Health Plan	25.3	30.7	23.5	2.9	17.6
No Health Plan	27	16.6	23	9.2	24.2

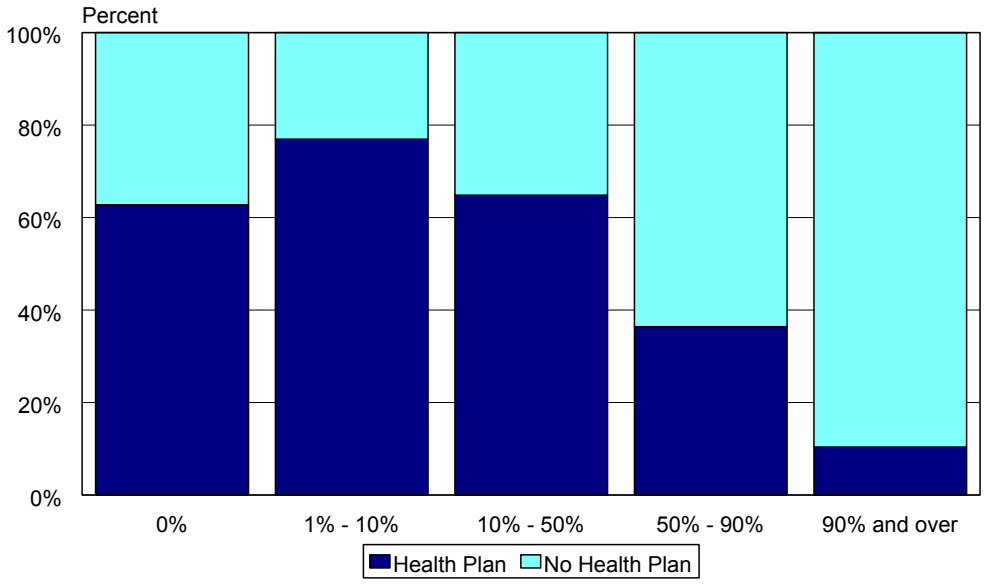
Source: Center for Applied Demography and Survey Research, University of Delaware

There is a great deal of similarity between the two sets of firms with respect to health plan status. In fact about a quarter of firms in both categories are in the "no turnover" category. Firms with a health plan are more prevalent in the low turnover category (1%-10%) and firms without health insurance coverage are much more prevalent in the 50% and higher categories.

The relationship between health plan status and the turnover categories is also interesting (see Figure 3-10, below). The no turnover category is a special case and not having health insurance coverage obviously is not a problem for those employees. For the other categories, there is a clear decrease in the availability of coverage as the turnover rate increases. While there

certainly appears to be a relationship, the information is not sufficient to draw the conclusion that health insurance plans reduce turnover. Their existence is certainly correlated with turnover.

Figure 3-10
Firm Health Plan Status
by Turnover Rate



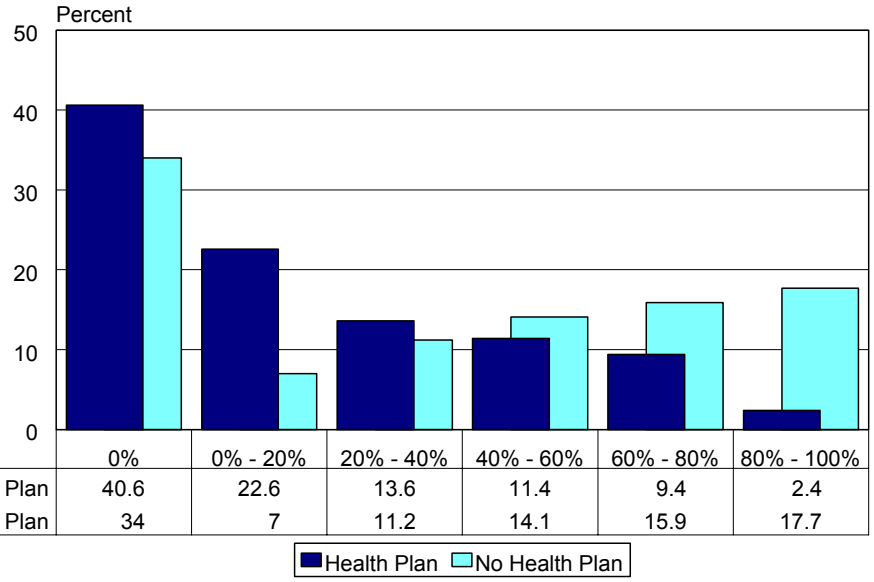
Source: Center for Applied Demography and Survey Research, University of Delaware

Turnover is probably more of an issue for firms that have a significant number of part-time employees. This is particularly true if the part-time employee is really not part-time by choice. In general, part-time employees rarely have access to a health plan especially if they are hourly workers. Thus, as the proportion of the employees in the firm who are part-time grows, one would expect the likelihood of having a health plan would fall.

In Figure 3-11, below, there are substantial differences in the way the two groups of firms are distributed across the percent part-time employment categories. Putting aside the special case of no part-time employees where there are similar proportions of both groups, the proportion of firms with no health plan increases consistently. At the same time the proportion of firms who have health plans falls in a systematic fashion.

This same relationship is even clearer in Figure 3-12, below. It offers the single strongest relationship in predicting whether a firm will have a health plan. For firms with less than 20% part-time employees, over 80% have health plans. For those with nearly all part-time employees, 80% do not have health plans.

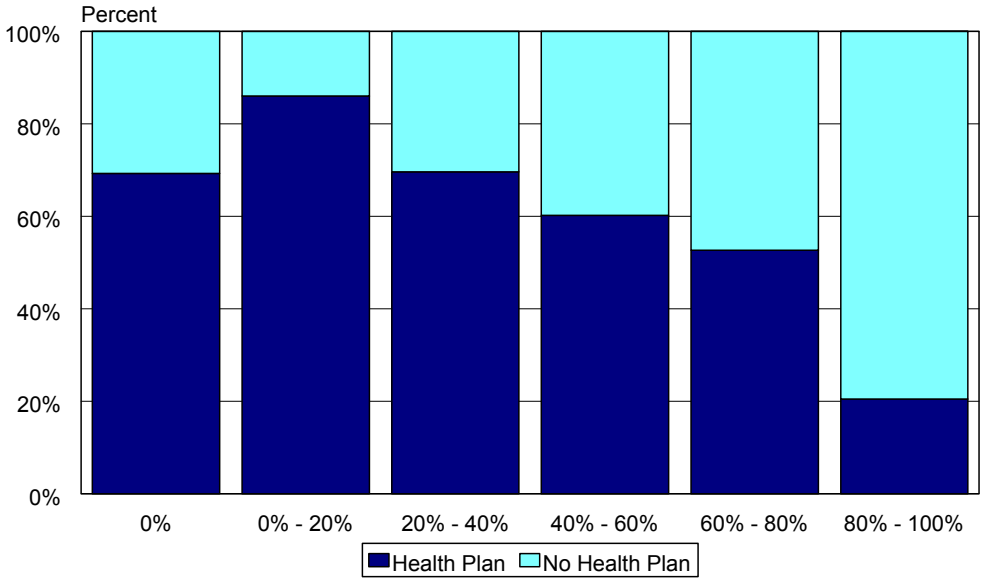
Figure 3-11
Percent Part-time Employees
by Firm Health Plan Status



	0%	0% - 20%	20% - 40%	40% - 60%	60% - 80%	80% - 100%
Health Plan	40.6	22.6	13.6	11.4	9.4	2.4
No Health Plan	34	7	11.2	14.1	15.9	17.7

Source: Center for Applied Demography and Survey Research, University of Delaware

Figure 3-12
Health Plan Status
by Percent Part-time Employees



Source: Center for Applied Demography and Survey Research, University of Delaware

Other variables were explored, but none offered significant insight into this issue:

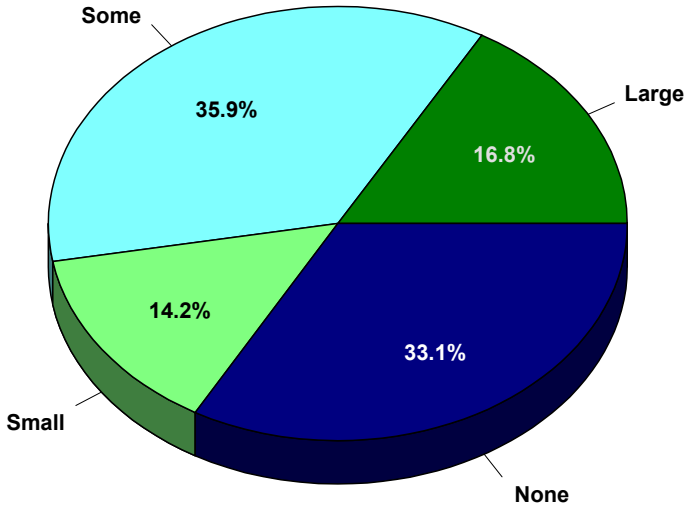
- Age of business should be related to size, revenue, and other key variables but this only made a small difference in the proportion having health plans for firms in business for 20 years or more.
- The firms in this study were more than 90% non-union and the differences in health status were insignificant largely because of sample size.
- The gender distributions between the two groups of firms were similar although firms with health plans had a higher proportion of males (60%). The higher proportion of females (50%) in firms without health plans is related to the differences in part-time workers.

Overall, the variables that explain the differences in having or not having a health plan seem directly related to the economic circumstances of the firm. In the next section, the data gathered from firms who do not have health plans will be explored in more depth.

Businesses Without Health Plans

Technically, no business is required to offer health insurance. It has been considered mutually beneficial to provide the benefit for a number of reasons. In addition, since the benefit is generally not taxable, the value to the employee is greater than the equivalent amount of salary. In spite of these factors, many firms do not offer benefits for a lot of different reasons. One of the overarching reasons for offering health insurance is that there is an obligation since this is how most people obtain insurance. The survey results for this question among those that do not currently offer insurance are displayed.

Figure 4-1
Obligation of an Employer
to Provide Health Insurance



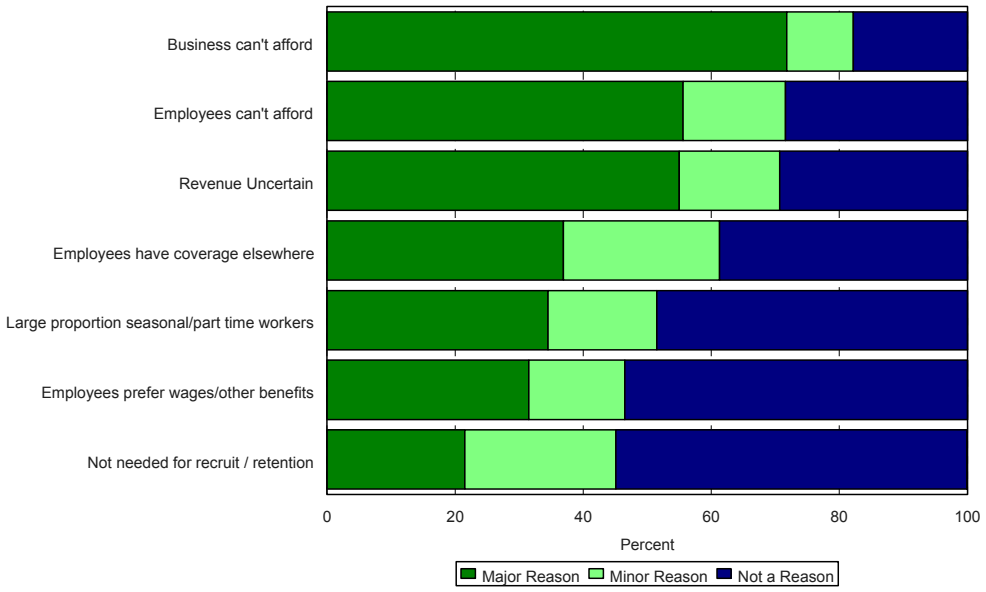
Source: Center for Applied Demography and Survey Research, University of Delaware

More than half of these firms feel that there is no obligation or only a small obligation to offer this benefit. It is interesting to note that among those businesses that do offer insurance, 66% stated that "It was the right thing to do" was a major factor in their decision. That also corresponds to 71% on a national survey of employers conducted in 2000 who felt the same. Clearly, there is a difference of opinion in this area.

One of the most important reasons for doing the employer survey was to gain some understanding as to why employers didn't offer health insurance. Figure 4-2 below sheds some

light on the issue. Employers were asked to classify seven areas as to whether each was a major reason, a minor reason, or no reason at all for not offering health insurance.

Figure 4-2
Reasons for Not Offering Health Insurance
by Level of Importance

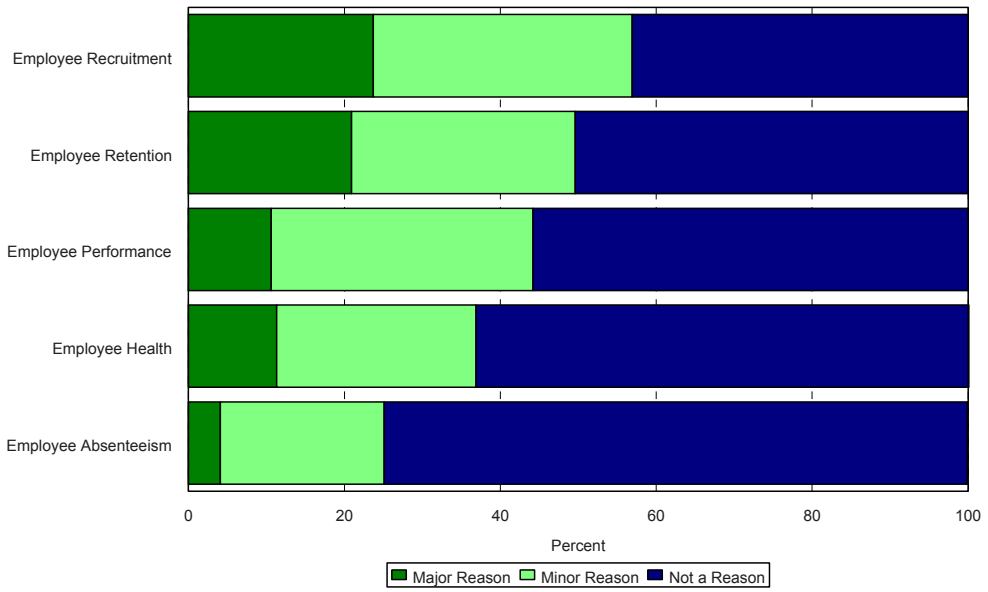


Source: Center for Applied Demography and Survey Research, University of Delaware

The top three reasons are related to simple economics for either the employer or the employee. The employer can't commit either because there are insufficient profit margins or because those profit margins are volatile. The employees on the other hand can't afford to pay their share since it would mean a substantial reduction in their disposable income. All three issues are related to the general problems faced by small businesses and their employees every day.

Once again the results from this survey were similar to those in the national poll. If any thing, the Delaware businesses were more certain that they couldn't afford to provide the health insurance (82% to 69%). They were also more certain that their employees could not afford their share (72% to 54%).

Figure 4-3
Impact of Not Offering Health Insurance
by Level of Importance



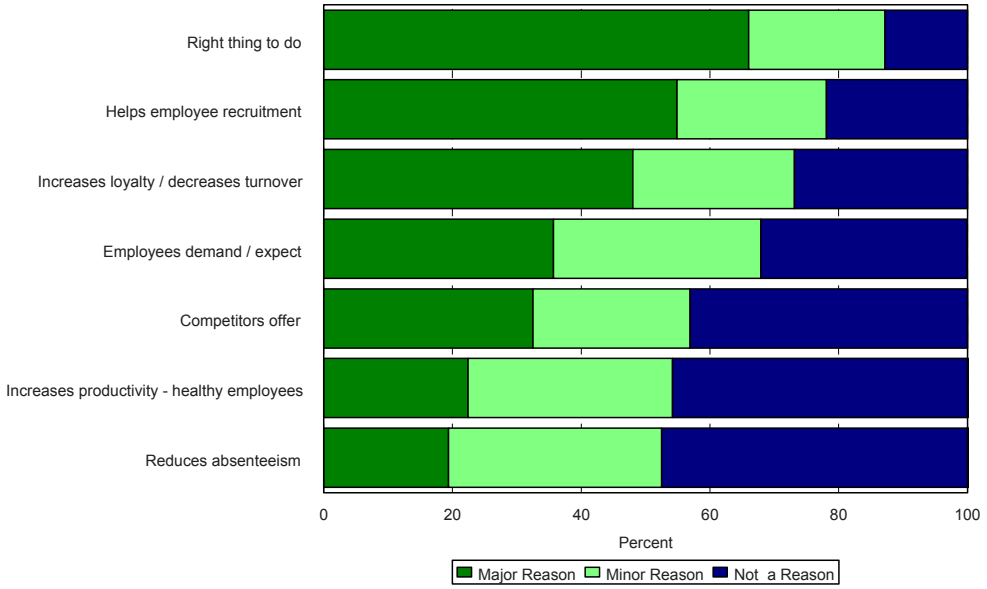
Source: Center for Applied Demography and Survey Research, University of Delaware

Ultimately, business owners will be unlikely to provide a benefit like health insurance if they feel it will make little or no difference to the business. Altruism was effectively ruled out in the earlier discussion. In Figure 4-3 above, only one of the potential positive reasons for offering this benefit is considered a reason for doing so by more than 50% of the businesses that currently do not offer health insurance coverage. However, only one in four consider offering health insurance coverage as having a major impact on employee recruitment.

In the national survey 70% or more of the small businesses responded that offering health insurance had no impact any of the five factors listed above. Generally, Delaware's small business owners were far less likely to agree with that assessment. That may reflect the tightness in Delaware's labor market over the past ten years. This chart coupled with Figure 4-2 could lead one to conclude that these businesses do see the positive aspects of offering health coverage although with modest levels of intensity, but economic factors make this impossible for many of them.

Just as small businesses have reasons for not offering health insurance, others have reasons for doing so. In the figure below, the importance of seven different reasons for offering health insurance are evaluated.

Figure 4-4
Reasons for Offering Health Insurance
by Level of Importance

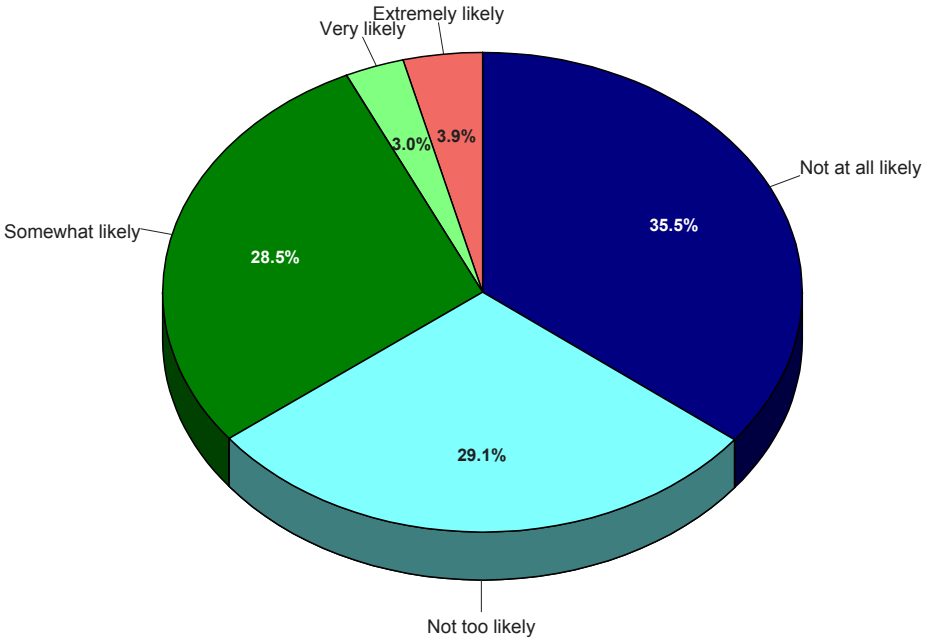


Source: Center for Applied Demography and Survey Research, University of Delaware

One of the interesting aspects of the information found in Figure 4-4, above, is the different level of intensity expressed by firms that have health plans in contrast to evaluations of the same or similar factors by firms that currently do not have health plans.

First, the fact that "it's the right thing to do" is the most important factor is in direct conflict with the level of obligation felt by business owners who currently do not offer coverage. Second, these firms rate recruitment and retention consistently higher in terms of the positive impact than the other firms rate the negative impact on the same items. Finally, while the ratings are lower for the remaining items, those without health plans consistently evaluated the items as even less important.

Figure 4-5
Likelihood that the Business Will Offer Health Insurance within Two Years

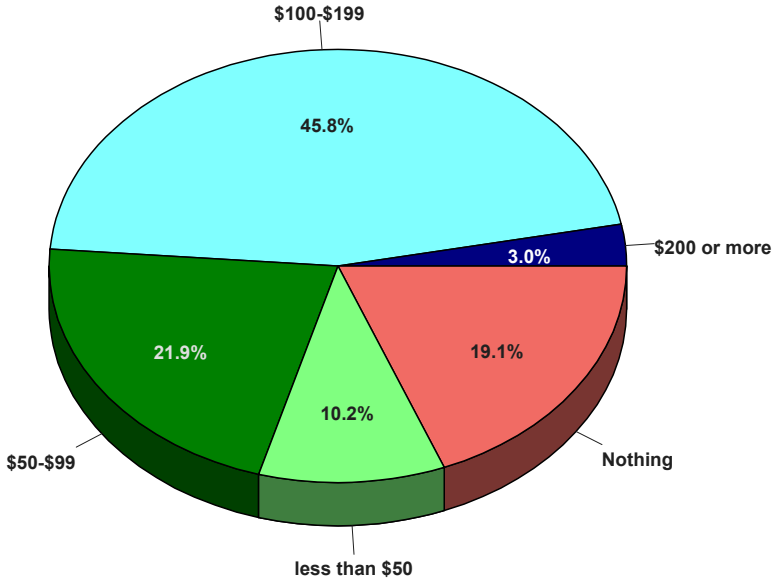


Source: Center for Applied Demography and Survey Research, University of Delaware

Among those businesses that do not currently offer health insurance coverage, 21% have offered coverage of some type in the last five years. That compares with 12% nationally. However, as can be seen in Figure 4-5 above, 65% effectively rule out starting a health plan for employees within the next two years. Approximately 13% of those that had previously offered coverage indicated that they are extremely likely or very likely to do so again. This compares with 5% of businesses that have never offered a health plan.

Perhaps one bright side of this data is that almost 44% of the businesses indicated that they have contacted someone about obtaining coverage. Presumably this means that the information received was not compelling enough to take the next step or that the cost was prohibitive. Once again, Delaware's businesses were more likely to have taken this step since only 31% of the national sample did so.

Figure 4-6
Amount the Business Would Be Willing to Pay
Per Month for Health Insurance



Source: Center for Applied Demography and Survey Research, University of Delaware

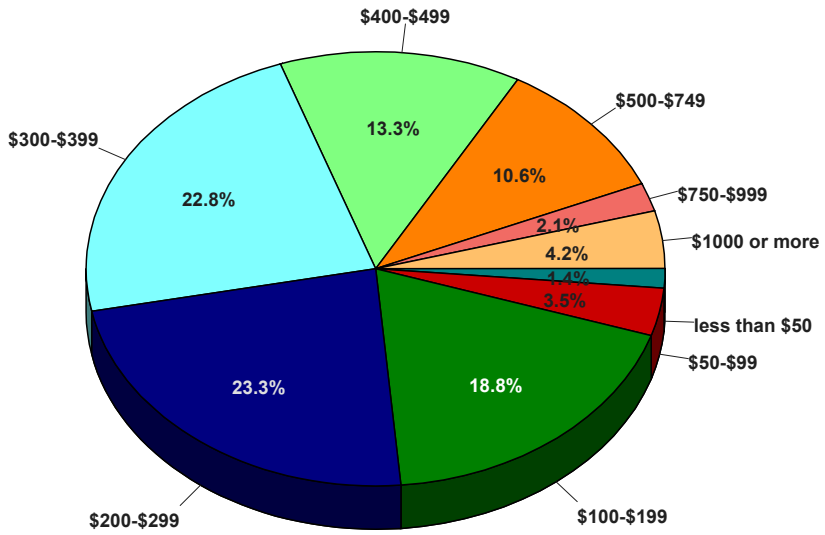
There is ample evidence provided in the survey that cost is one of the primary drivers in deciding whether or not to offer health insurance. In Figure 4-6 above, the amounts that employers would be willing to pay to cover their employees are shown. First of all, its important to note that two-thirds of the respondents could not or would not make an estimate as to the amount that they would be willing to pay. Thus, the chart refers only to those who would hazard an estimate. Overall, these data are similar to that derived from the national survey.

If a typical plan costs $2800, including both the employer and the employee shares, then about half of those responding would be willing to cover half of the annual cost for their employees. For the typical employee making $8 per hour in these businesses, the employee share amounts to a 10% reduction in pretax wages. In contrast, employees in firms that offer insurance typically earn 50% more or $12 per hour with a correspondingly lower proportional outlay in pretax wages.

Just under half of these businesses that do not offer health insurance coverage have inquired about coverage in the past year. This would imply that they have some understanding of the costs of such a benefit. Respondents were asked about the cost of typical health insurance

coverage. In this case almost 70% could provide an estimate and those responses are found in Figure 4-7, below.

Figure 4-7
Amount that Health Insurance Would Cost Monthly Per Employee

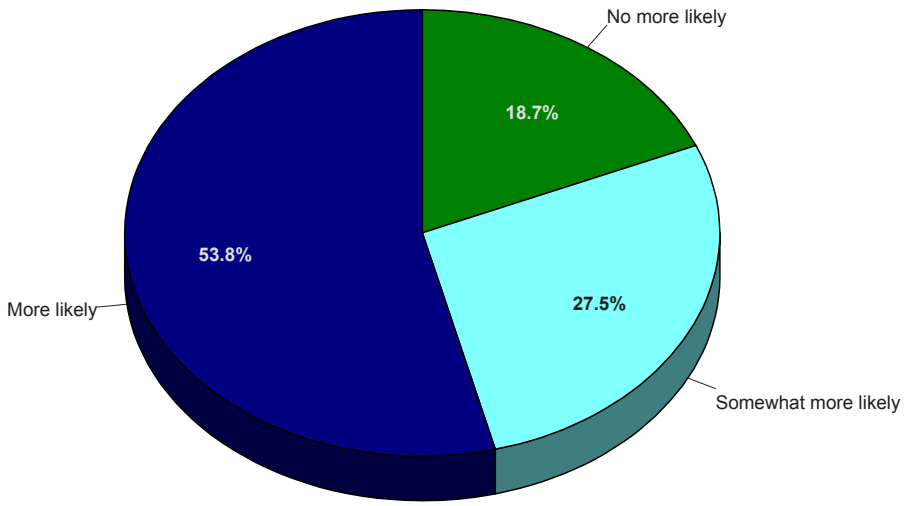


Source: Center for Applied Demography and Survey Research, University of Delaware

The first important aspect of this chart is that 53% of the businesses estimate costs $300 or above when the typical cost for employee and employer together is closer to $220 per month. In the national survey, only 33% of businesses provided estimates above the typical cost. It was also interesting to find that the accuracy of the estimate varied little between those that had recently asked about coverage and those that had not. It also might mean that businesses tend to get estimates on a high benefit plan as opposed to bare bones plan.

One conclusion that could be drawn as to why some businesses do not offer health insurance coverage is that they have not carefully reviewed the range of options that are available. However, it also may be that the time cost of this search process is excessive so that many never even start the search until some motivating factor is in place e.g. a key employee or recruit is adamant.

Figure 4-8
Government Assistance Would Make the Business More Likely to Offer Health Insurance



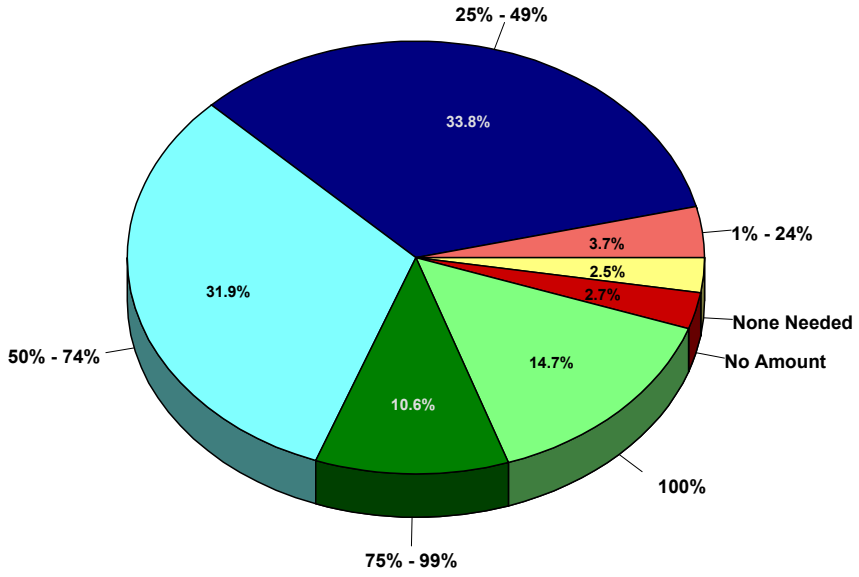
Source: Center for Applied Demography and Survey Research, University of Delaware

One potential way to increase the probability that a business will offer health coverage is to offer incentives that reduce the economic cost of doing so. It also may make it possible to increase the employer share from 50% to 80% and thus increase the probability that a low wage employee will take the coverage.

In Figure 4-8 above, more than 80% of the businesses surveyed said that the likelihood of offering health insurance coverage would increase if there was an incentive. In the national survey only 64% fell into those two categories. However, the question remains as to how much an incentive (subsidy) would be required to make a measurable difference in the number of businesses offering coverage.

To add some reality to the question of what proportion the government should pay of the employers cost, respondents were asked for an estimate. Any time a survey question of this type is asked, one can safely assume the respondent will lean in the direction that favors their situation. This type of result is evident in Figure 4-9, below.

Figure 4-9
Percentage Government Would Have to Pay for the Business to Offer Health Insurance



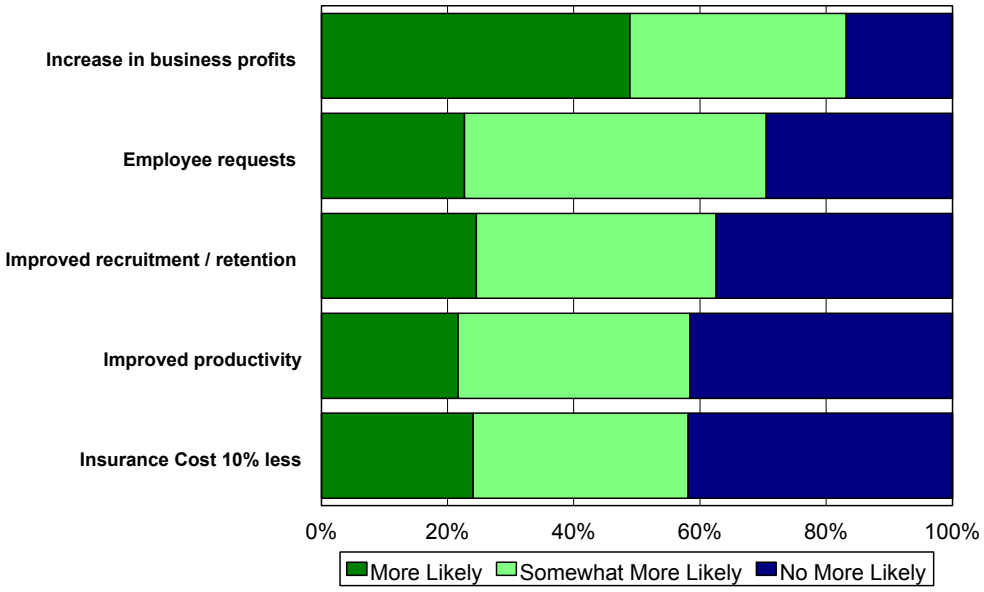
Source: Center for Applied Demography and Survey Research, University of Delaware

It is probably safe to say that government is highly unlikely to pay more than 50% of the cost of health insurance for small businesses like these given crowd-out issues and the total cost. There are however programs where government has paid up to one-third of the total cost for selected employers in order to gain some participation and to bring the cost to employees within a reasonable range.

From the chart, one would say that about 40% of small businesses that do not currently offer health insurance might be influenced if the government would subsidize up to 50% of the premium. That suggests that only half of the original 80% (see Figure 4-7) who originally said they might offer health insurance with a subsidy, would actually receive a subsidy sufficient to commit to offering coverage. These estimates also correspond very closely to the national survey where 40% of the businesses providing an estimate expected a subsidy of less than 50%.

Most of the data examined thus far suggests that most of the small businesses that currently do not offer health insurance coverage may be difficult to convince to change their ways. The economic issues predominate and this is reflected in Figure 4-10 below.

Figure 4-10
Factors that Might Influence the
Likelihood of the Business Offering Health Insurance



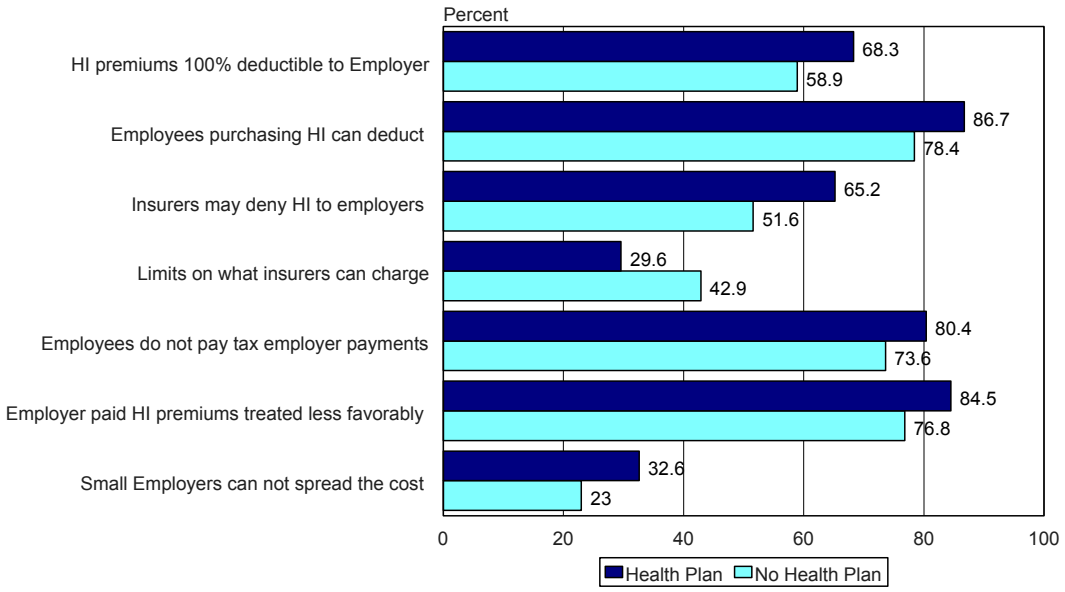
Source: Center for Applied Demography and Survey Research, University of Delaware

These businesses were also asked what factors might be influential in changing their decision on offering health coverage. The responses were somewhat predictable. Any factor that touched the business bottom line in a positive way was seen in a favorable light.

This discussion has only dealt with health insurance for the employee and does not address family coverage. Since family coverage averages three times the cost of covering an individual, it is unlikely that these businesses will take that path unless pressed by a key employee or forced by competition for workers. In addition, typical employee shares of the total cost of health insurance are closer to 15% than 50% for those businesses that currently offer the benefit. In short, it may be difficult to induce this group of employers and employees to

Finally, the question arises as to whether the firms that do not have health plans hold some misconceptions about the product and the process. There was some evidence presented earlier that is consistent with that view. To test this hypothesis a set of seven true-false questions dealing with health insurance were asked of both groups of firms. The results are displayed in Figure 4-11, below.

Figure 4-11
Percent Answering the Question Correctly
by Firm Health Plan Status



The full text of the questions asked were as follows:

1) Health Insurance premiums are 100% tax deductible to the employer (true);
2) Employees who purchase health insurance on their own generally can deduct 100% of their health insurance premiums for federal income tax (false).
3) Insurers may deny health insurance coverage to employers with 2 to 50 employees due to health status (false).
4) There are limits on what insurers can charge employers with sick workers (true).
5) Employees do not pay tax on the share of their premiums that are paid by their employer (true).
6) Employer paid health insurance premiums are treated less favorably than general business expense with regard to taxes (false).
7) Small employers cannot spread the cost of sick employees across a large pool of workers (false).

On six of the seven questions, those firms with health plans answered correctly more often although the differences were not large. Probably the single most startling result is the fact that neither group did very well on the first question dealing with the deductibility of employer paid health insurance premiums.

OBSERVATIONS

This investigation of health insurance coverage among Delaware's employers with particular emphasis on the small employer has been revealing. During the survey, it was very clear that this topic was on the minds of small employers whether they currently had a health plan or not. They responded at rates much higher than experienced previously in this state and at substantially higher rates than in the national study. In addition, a significant number of employers provided written comments detailing their concerns about the health insurance problems with which they are faced. The information presented here coupled with other data not detailed suggests that solving the lack of employer paid health insurance among smaller firms will not be easy.

- If the sample of small employers that do not currently have health plans had looked like a random sample drawn from all small employers it might have been concluded that the problem was manageable. However those that do not have health plans are not like those that do.

- Small employers that do not have health plans are generally smaller than those that currently have them.

- Small employers that do not have health plans have significantly more part-time workers who rarely qualify for health benefits even when working for employers that have health plans.

- Both salaries and hourly wages are lower in those firms that do not currently offer health plans. This suggests that those businesses would be paying disproportionate amounts for of the total cost of employment if they offered health care benefits. In addition, workers faced with perhaps paying 50% of the cost would find that an unacceptable reduction in take-home pay.

- Small employers that do not have health plans tend to have higher turnover rates than in those firms that have them. This is not unusual given the concentration of part-time jobs. It is also likely that firms with higher turnover rates would have tried to reduce them by paying higher rates of pay and benefits if it was to their economic advantage. In other words if the costs of turnover were less than the cure, they will not take the cure.

- Small employers that do not have health plans seem to understand the basics of health plans as well as those that currently have them. They also seem to periodically check in with insurers to see if there might be a plan for them. Thus,

the provision of additional information is likely to have a positive but small effect on these employers.

- Small employers without health plans see less positive benefit coming from providing health coverage. Issues such as recruitment, retention, productivity, and absenteeism do not register anywhere as near as high on the scale as they do for those that already have plans.

- While small employers overestimate the true cost of a health plan, the amount that they are willing to contribute is probably insufficient to make a standard plan viable. In addition the amount they would expect the government to subsidize is also probably unrealistic.

- If a significant proportion of these small employers without health plans are to change their position, it will take a multi-pronged approach of improved information, government subsidies, limited benefit plans, and other innovative approaches to make it happen.

APPENDIX C:

FOCUS GROUP SUMMARY REPORT

Summary of Focus Groups for the Delaware Health Care Commission

Recruitment

Although the Delaware Chamber of Commerce, and several local Chambers of Commerce had been contacted to assist with, and had agreed to, recruit small business owners and employees for the focus groups, recruiting was inordinately difficult.

The focus groups were originally scheduled for May 8th and 9th. Upon contacting the Chambers, all reported a lack of ability to recruit members for the focus groups. The New Castle Chamber of Commerce and the Central Delaware Chamber of Commerce reported that business owners did not want to take the time away from their businesses to participate in the two hour sessions. The decision was made to offer stipends to participants to compensate them (in some small way) for their time: $100 to Business Owners; $50 to Employees of Small Businesses.

The Delaware State Chamber of Commerce forwarded their list of members (650 names), and between April 26th and May 1st , 177 businesses were contacted by HMA staff. Fifty-four reported having health insurance for their employees; 6 business owners agreed to attend; 1 said "possibly" they would attend.

On May 3rd the decision was made to postpone the focus groups and pursue other avenues for recruitment. The dates were changed to May 30th and May 31st. The six participants were contacted and four were able to be re-scheduled to the new dates.

Additionally, contacts were made with the Delaware Association of Non-Profit Agencies (DANA) and the Delaware Chapter of the National Federation of Independent Businesses (NFIB), and recruiting letters were sent to each to be forwarded to their members. DANA reported forwarding the information to approximately 150 of 300 members. NFIB reported forwarding the information to a 17 member "leadership council".

Participation

On May 30th, two focus groups were conducted in Dover, Delaware.

The Employer/Business Owner group was held from 11am to 1pm, with 8 participants – one of which was contacted by NFIB and one of which was contacted by the Association of Non-Profit Agencies.

The Employee group was held from 3pm to 5pm, with two participants – one of which was contacted by NFIB and one of which was contacted by the Association of Non-Profit Agencies.

On May 31st, two interviews were conducted in Newcastle, Delaware.

The Employer/Business Owner group was held from 8:30am to 10:30am with one participant, who was contacted by the Association of Non-Profit Agencies.

The Employee group was held from 11:30am to 1:30pm with one participant, who was contacted by the Association of Non-Profit Agencies.

Findings

The focus group discussions were divided into four main sections: Issues and Problems of Small Businesses; Benefits; Health Insurance; and Reaction to the Options for Coverage Expansion.

Issues and Problems of Small Businesses

The Employers/Business Owners reported that cash flow, employee dedication, employee retention/turnover, and recruitment of employees are their most pressing issues. They also stated that it is "more expensive" for small businesses to offer the same benefits that larger corporations offer, and that the percentage of revenues devoted to benefits for employees is much higher for small businesses. They also reported that is harder to attract and retain employees now than it was a year ago. All emphasized that they offer greater "flexibility" as an incentive to attract and keep good employees (An example of the needs of a working parent was given.)

Employees also understood the tight financial constraints of their employers.

Benefits

Most Employers/Business Owners reported that health insurance is the most important benefit that can be offered to an employee, but one offered that they are very generous with "free" benefits, such as flex time, vacation time, sick leave, holidays, etc., even for part-time employees.

One business offers employees $860 annually to be used toward health insurance or medical expenses, and this benefit was highly valued by one of the employees who attended the Employee group because it could be used for expenses such as eyeglasses, counseling sessions (as needed), and other miscellaneous medical expenses.

Employees faced with the question of changing jobs to receive health insurance, stated that would be a difficult decision.

Health Insurance

Three of the participating employers reported that they have insurance themselves, but did not offer it to their employees.

Great concern was expressed over two issues:

- The medical underwriting of small groups, and the dramatic premium increases when a member gets sick – one participant reported that her husband had a

pacemaker, and their premiums increased from $847 per month to $1400 per month, but she could not change plans because of the pre-existing condition.
- The high, and increasing, costs of prescription drugs.

The sources of information regarding health insurance included insurance agents, chambers of commerce (who offered plans in the past, but do not currently), mail solicitation, and telephone calls.

The single most important barrier to offering health insurance is cost. This is influenced by the medical underwriting, and rates set according to health condition of employees. Two of the employers reported that all of their employees are covered by another source.

Most participants believe that there is an obligation on the part of the employer to provide health insurance coverage. Only one participant stated that she does not think employers should pay for health insurance, "because we pay for workers' compensation anyway."

Most participants also believe that employees have an obligation to pay for part of their health insurance coverage, but some stated that employees cannot afford to do this. One participant suggested that possibly the state or federal government could pay the portion of the premium that an employee cannot afford to pay.

The perception among business owners is that state and federal funding is available for programs for the uninsured – the federal surplus and the tobacco money were specifically stated.

Lastly, there was great frustration among all participants over the insurance companies' and pharmaceutical companies' high profits. It was suggested more than once that government should "take a look" at the practices of these industries and "set controls." (A $3.7 million salary for a health plan CEO, and $18 for a 15 cent pill were stated as examples.)

Reaction to the Options of Coverage Expansion

Ten concepts were presented. The most popular concept was the opportunity to buy-in to the state employees health plan, but with the important change that it be available to all employees (including owners) of small businesses, on a sliding scale (with no subsidy above a certain income).
The state employee plan is perceived to be a rich benefit package, with affordable rates, due to the fact that the state is able to "negotiate" with providers.

The options to buy into the Delaware Healthy Children Program was perceived by some participants as "discriminatory" because it was only available to people with children.

The Subsidized Employer-based program, such as the Wayne County model, was deemed too complicated by some participants, but was of interest to others.

The Limited Benefits plan (IHP) was not supported, because it is believed that if a hospital stay or surgery is required, hospitals will "come after you" and doctors will avoid surgery because they will not be paid for it. "What happens if you go to the doctor for a check-up and they find something wrong?"

Purchasing pools were also considered too complicated and the participants did not like the idea of "setting up another level of bureaucracy".

Reactions to the single payor model were mixed, although it was suggested that as a small state, Delaware might be a good place to try this.

Tax credits for individuals were considered more paperwork, and of little benefit in solving the problem.

The first group of employers insisted on adding Option #11 which is "better regulating and imposing price caps on insurance companies and pharmaceutical companies".

Finally, it was stated that the issue not be framed solely as expanding coverage for the uninsured, but that concern and consideration also be given to keeping insurance affordable to those who have it.

APPENDIX D:

FULL RANGE OF OPTIONS

The Range Of Options For Expanding Coverage

In deciding how to choose from the range of options available for extending coverage, the work group decided to begin with the full range of possible options, ruling nothing out initially. In compiling the list, the consultants who provided technical assistance made no attempt to assess the appropriateness or feasibility of any approach for Delaware's specific situation, but rather identified the wide range of options that might be undertaken by a state. Thus they work group began by looking at the following categories of options, reviewing the approach, the target population, the advantages and disadvantages, and the sources of funding for each.

1. *Tax Credits to Low-Income Households*

   The state would supply tax credits to households falling below some income level, which they could apply to the cost of individual insurance or to pay the employee portion of the premium for employer-sponsored insurance. Their state income tax liability would be reduced by the amount of the tax credit.

   Decision. This approach was viewed as being impractical for Delaware. Because most of the target populations have little taxable income, to be effective, the credits would have to be "refundable" (that is, people could get "money back" if their credit was larger than their tax liability) and payable in advance (before the time taxes are due). This was deemed too expensive and too complex administratively. Moreover, to the extent that people use the tax credit to buy insurance in the individual market, the approach sends people to the portion of the insurance market where there is much risk segmentation, where rates can vary greatly depending upon risk status, where administrative costs are high, where applicants can be denied coverage, and where it is more difficult for people to get good information to ensure that they are getting a "good deal." Further, the crowd-out problems associated with this approach could be severe.

2. *Tax Credits for Employers to Encourage Them to Offer Coverage*

   The state would extend a tax credit to employers who newly offer health coverage to employees to offset some of the employer's cost. The expectation is that some employers, now able to subtract a portion of coverage costs from their state tax liability, would be induced to offer and pay for a portion of coverage for their employees.

   Decision. This approach was viewed as being impractical for similar reasons to those that apply to the previous approach. Many employers not now offering coverage are likely to be small, marginal firms, hiring low-wage employees. They may not generate significant profits and thus may not incur much of tax liability; so unless the tax credit was "refundable" and quite large, they might not get much benefit from a tax credit and thus would not participate. Employers would still have to pay a significant portion of the premium from their own funds, which may be more than marginal firms can afford; and employees might decline coverage rather than pay the

employee portion of the premium. The budgetary cost and the crowd-out potential were further reasons to rule out this approach.

3. *Subsidized Buy-in to State Employees' Plan*

   The state would allow eligible low-income people to buy-into the state employees plan, which would give small businesses and individuals the advantage of being able to buy coverage at the favorable rates that the state presumably gets as a major purchaser. To make coverage even more affordable, needy people might be allowed to buy in at a price below the full premium cost. If the premium were subsidized, the amount enrollees pay out of pocket for their portion of the premium would be based on their income level and thus their ability to pay.

   Decision. This approach was ultimately rejected for a variety or reasons, the most compelling of which was the strong conviction on the part of many people that it was neither politically feasible nor practical to combine the state employees' plan with a subsidized plan for the uninsured. This position was strongly held even when it was made clear that the state employees and the newly enrolled people could be in separate risk pools so that state employees' premiums would be unaffected by the medical experience of the people in the plan who are not state employees. Even though this option was set aside, the discussion of this approach led to another option that combines some elements of this approach with a subsidized purchasing pool approach, and this option is one that the work group recommended for further development. It is discussed more fully below.

4. *Extending Medicaid Coverage to Parents for Families with Incomes Beyond the Current 100 Percent of Poverty – Without An 1115 Waiver Modification*

   Delaware has a current 1115 waiver under which Medicaid coverage is extended to all individuals with incomes below 100 percent of the federal poverty level. This includes single individuals and childless couples that are not part of traditional Medicaid categories. However, the state could perhaps extend coverage up to 150 percent of the federal poverty level because federal welfare reform legislation allows state Medicaid programs greater flexibility in treatment of the income and assets of low-income families under section 1931(b) of the Social Security Act. While the states cannot increase the TANF-related income threshold for Medicaid eligibility by more than the increase in the Consumer Price Index, the State can change the way it counts income and/or assets, or increase the threshold for allowable assets. Delaware could, for example, disregard the first $1,500 of monthly earned income for a Low Income Family of three, thereby indirectly increasing the income level at which parents would be covered by Medicaid to around 150 percent of the poverty level.

   Decision. The approach was ultimately rejected because a somewhat similar expansion of the S-CHIP program seemed a better alternative. In particular, under the S-CHIP option the state would receive more in the way of federal matching funds.

5. *Extending S-CHIP Coverage to Parents in Families with Incomes Beyond the Current 100 Percent of Poverty*

   Delaware's current 1115 waiver extends Medicaid coverage through the Diamond State Health Plan to all individuals with incomes less than 100 percent of the federal poverty level. Children in families with incomes between 100 percent and 200 percent of poverty level are covered by Delaware's S-CHIP program, but adults beyond 100 percent of poverty are not eligible for public coverage programs. Because it has unused S-CHIP funds, Delaware could seek a S-CHIP 1115 waiver to extend coverage to parents of S-CHIP kids (for example, to parents in families with incomes between 100 percent and 200 percent of the poverty level).

   Decision. This approach was one that is considered worthy of further development. It is discussed in more detail in the section on options deserving of further development.

6. *The Reduced-Benefit "One-Third Share" Program*

   This is a subsidized coverage program with more limited benefits than a typical comprehensive plan so that the premium for employers and employees can be kept low enough to make the plan financially attractive (in the range of $1,500 to $1,800 per year). Typically, the premium is shared equally among the employer, the employee, and government.

   Decision. This option was seen as being worthy of further development and is discussed in more detail below.

7. *Limited Benefit Programs*

   Under this option, low-income individuals who are not eligible for Medicaid or S-CHIP are allowed to enroll in a program which typically covers primary care (which is capitated), specialty care (which is prior authorized), laboratory and radiology (contracted with specific providers), and prescription drugs (with a formulary that includes primarily generics and is restrictive). Hospital care is not covered. If the enrollees require acute care, they fall back to the safety-net system on which they previously depended for *all* care.

   Decision. This option was seen as being worthy of further development and is discussed in more detail below.

8. *Premium Assistance through S-CHIP for Available Employer Coverage*

   This approach takes advantage of federal regulations that permit states to subsidize the purchase of employer-sponsored coverage for parents of S-CHIP-eligible children who work for employers that offer coverage. The state would supplement the amount that the employer contributes for *both* the parents and their children's coverage. Federal regulations require that the plan be budget-neutral, which is often possible because the employer provides a portion of the financing for both the parents' and the children's coverage.

Decision. Although the approach was not initially viewed favorably because of onerous and complicated federal requirements, new federal policy appears to make it substantially easier to implement this approach. As a consequence, the work group has tentatively concluded that this approach may deserve more careful consideration.

9. *Small-Group and/or Individual Insurance Reforms*

   This approach involves trying to broaden the insurance risk pool to make coverage more affordable for higher-risk groups or individuals. The possibilities include restricting insurers' flexibility in setting rates based on health status and some other factors in both the individual and small-group markets and limiting insurers' ability to deny coverage to applicants in the individual market (already prohibited in the small-group market). An additional option would be to require all insurers to share in losses that health plans and insurers incur in covering high-risk individuals (and perhaps groups).

   Decision. This approach was rejected for several reasons. First, these policies make coverage more affordable only for high-risk people who could afford normally priced coverage. Second, Delaware has already passed some insurance reforms for the small-group market; more restrictive rating policies seem impractical in a small state like Delaware, where there is a danger that insurers might leave the small-group market rather than conform to what they see as onerous requirements. Third, it is very difficult to devise policies for the individual market that do not create as many problems as they solve because of the fact that individuals often wait to buy coverage until they anticipate needing expensive medical care. As a result, policies which would require insurers to provide coverage on a guaranteed-issue basis or to rate individuals on a community-rated basis would be unlikely to produce the desired results, since they would produce even stronger incentives for individual to wait to buy coverage until they anticipated incurring large medical expenses.

10. *Health Insurance Purchasing Cooperatives*

    Delaware could sponsor purchasing cooperatives (HPC) to allow small employers to pool their purchasing power and collectively purchase health coverage. The cooperative would offer coverage by signing contracts with health plans that agree to offer a set of standardized benefit products to any small employer that chooses to buy through the HPC. The expectation is that with the purchasing clout of many small employers purchasing collectively, the HPC will be able to do what large employers do: bargain for better premiums and realize administrative savings, thus making coverage more affordable. An alternative form would involve having the state subsidize the cost of coverage for low-income workers or individuals who buy through the purchasing cooperative.

    Decision. Initially the work group concluded that the experience with purchasing cooperatives in other states, particularly their inability to attract large numbers of small employers or to retain participation of health plans, made this an unpromising approach. However, as the discussion of the state employee buy-in approach evolved, the group concluded that certain elements of the purchasing cooperative

model should be considered in developing a new approach to permit low-wage workers and low-income individuals to buy coverage through a mechanism that is more efficient than the current small-group market. This is discussed in more detail in *** below.

11. *"Bare Bones" Insurance — Catastrophic Coverage*

The legislature could permit insurers to sell a "bare bones" insurance package that would cover only expenses past some relatively high level—perhaps $1,500 for an individual and $3,000 for a family. Because the coverage would be less expensive than more comprehensive benefit packages, it might be more affordable while still fulfilling the real function of *insurance*, which is to provide financial protection against very large unpredictable expenses.

Decision. This approach was rejected because of the evidence that the policies that provide such coverage do not attract many buyers. Today people evidently expect health coverage to cover the more common kinds of medical costs that they incur, not just the catastrophic events. Moreover, insurers in Delaware already have the authority to sell policies of essentially this type, in the form of major medical coverage.

12. *"Bare Bones" Insurance — Primary Care Coverage*

The legislature could permit insurers to sell a "bare bones" insurance package that included coverage for only cost-effective primary care, preventive services and prescription drugs. This would require that the legislature waive mandated benefits for this particular insurance package. This insurance might appeal to lower-income people because the cost would be relatively low, and they would be more likely to purchase it than catastrophic coverage because they would anticipate using the covered services. If these people needed hospitalization or other acute-care services, they would be no worse off then if they had no insurance. They would have to seek charity care from safety net providers, as they do now.

Decision. The benefit structure of this approach is incorporated in option *** discussed below, although as incorporated in that option, the people covered by such structures would pay little or nothing toward the premium. Instead, it would be subsidized for low-income people not eligible for other public programs. The idea of offering such policies to the public in general was not supported, in part because of the concern that some people who could afford more comprehensive coverage might buy this coverage and would then not be protected against the possibility of incurring catastrophic events.

13. *Employer "Play or Pay" Mandate*

The state could require that all employers either offer coverage to their employees and pay at least some minimum proportion of the cost of the premium (the "play" option) or, alternatively, pay a tax approximately equal to the employer's portion of the cost of providing coverage had the employer chosen the play option (the "pay"

option). The state would use the tax money collected from "non-playing" employers to finance subsidies for their employees to buy coverage on their own.

Decision. This approach was rejected in part because it was deemed to be politically unacceptable because of the degree of compulsion involved. Moreover, marginally profitable employers paying minimum wages might be forced to lay off workers, since their relatively low productivity would not justify increasing their total compensation. Further, the approach would very likely be challenged under ERISA, which, in effect, prohibits states from regulating the health benefits of self-insured employers.

14. *Mandate that Individuals Have Coverage*

    The state could pass legislation requiring everyone to acquire health coverage of one kind or another. Individuals who nevertheless failed to acquire coverage could be required to pay an amount equal to the cost of coverage as an addition to their state tax liability.

    Decision. This approach was viewed as being politically unacceptable. The compulsory nature of mandates would be objectionable to many people. Moreover, mandating coverage does not make it more affordable for low-income people, who would thus need substantial subsidies if they are not to forced be to take on an unmanageable burden.

15. *The "Single-Payer" or Social Insurance Approach*

    The state would guarantee that all Delaware citizens are automatically covered for a defined set of health care benefits, which would be publicly financed. Similar to Part A hospital coverage under Medicare, coverage under the system would be a "right" of all citizens and would not be dependent upon meeting any tests of eligibility based on need, family status, or other personal characteristics. No premium payments would be required for the basic coverage benefits.

    This approach has a history of interest and support from some groups within Delaware, and the work group believed it deserved consideration for that reason. However, the work group concluded that this approach is politically unacceptable and is not practical for Delaware to adopt on its own at any time in the near future. The single-payer approach is not one that is easily adaptable to adoption by a single state. People from other states who have very serious illnesses not covered by insurance would have strong incentives to move to Delaware to get no-cost coverage. In addition, the approach represents such a major departure from the way the health care financing and insurance systems are organized that it would require major institutional and administrative restructuring that could not be put in place without a very substantial lead time. Moreover, because the state would now be paying for a very large proportion of health costs now covered by employer and employee premiums contributions, the cost to state government would be very high (probably over $1 billion per year), requiring a major increase in state revenues. The financial burden would be exacerbated because there is no mechanism within current federal

law for capturing money now provided to the state by the federal government for Medicaid and S-CHIP (and other smaller federally subsidized programs).

APPENDIX E:

COST AND TAKE-UP RATE ESTIMATES PER OPTION

LIMITED BENEFIT PLAN ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS)

Number Eligible	12,700
Number Taking Up	5,000 – 7,000
Percent Taking Up	40% - 60%
Annual Total Cost (millions)	$2.0 - $4.2
Annual State Cost (millions)	$2.0 - $4.2
Per Capita Cost	$400 - $570
State Cost per Newly Covered Person	$400 - $570
Funding by Source (%)	
Contribution by Insured Individual	0%
Contribution by Employer	0%
Federal Share	0%
State Share	100%

ONE-THIRD SHARE PLAN ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS)

Number Eligible	7,400
Number Taking Up	800 – 1,200
Percent Taking Up	11% - 15%
Annual Total Cost (millions)	$1.5 - $2.2
Annual State Cost (millions)	$0.5 - $0.7
Per Capita Cost	$1,800
State Cost per Newly Covered Person	$600
Funding by Source (%)	
Contribution by Insured Individual	33%
Contribution by Employer	33%
Federal Share	0%
State Share	33%

S-CHIP EXPANSION ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS), ASSUMING NO CROWD-OUT EFFECTS

Number Eligible	16,500
Number Taking Up	2,900 – 7,700
Percent Taking Up	18% - 46%
Annual Total Cost (millions)	$1.5 - $2.2
Annual State Cost (millions)	$1.2 - $4.7
Per Capita Cost	$1,200 - $1,700
State Cost per Newly Covered Person	$430 - $610
Funding by Source (%)	
Contribution by Insured Individual	33%
Contribution by Employer	33%
Federal Share	0%
State Share	33%

S-CHIP EXPANSION ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS), WITH CROWD-OUT EFFECTS INCLUDED

Number Eligible	42,400
Number Taking Up	4,800 – 12,000
Percent Taking Up	11% - 29%
Annual Total Cost (millions)	$6 – $21.7
Annual State Cost (millions)	$2 - $7.5
Per Capita Cost	$1,250 - $1,800
State Cost per Newly Covered Person	$440 - $625
Funding by Source (%)	
Contribution by Insured Individual	33%
Contribution by Employer	33%
Federal Share	0%
State Share	33%

SUBSIDIZED PURCHASING POOL ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS), WITH STATE ABSORBING ALL ADVERSE SELECTION COSTS AND EMPLOYER AND EMPLOYEES SHARING EQUALLY IN THE PREMIUM

Number Eligible	46,700
Number Taking Up	13,300 – 18,800
Percent Taking Up	29% - 40%
Annual Total Cost (millions)	$28.7 - $57.8
Annual State Cost (millions)	Less than $1- $16.6
Per Capita Cost	$2,150-$3,100
State Cost per Newly Covered Person	$100 - $880
Funding by Source (%)	
Contribution by Insured Individuals	81% - 58%*
Contribution by Employer	13% - 19%
Federal Share	0%
State Share	1% - 29%

*Although the employee share is 50 percent when those signing up are part of an employer-sponsored plan, individuals enrolling on their own would pay 100 percent of the cost. Since the estimates assume large numbers of such individuals opt for this plan, the insured individuals' share averages well above 50 percent.

SUBSIDIZED PURCHASING POOL ESTIMATED COST AND TAKE-UP RATES (2000 DOLLARS), WITH STATE ABSORBING 50 PERCENT OF ADVERSE SELECTION COSTS AND WITH REMAINDER OF PREMIUM BEING SHARED EQUALLY BY STATE, EMPLOYER, AND EMPLOYEE (ONE-THIRD EACH)

Number Eligible	46,700
Number Taking Up	14,500 – 20,500
Percent Taking Up	31% - 44%
Annual Total Cost (millions)	$31.4 - $63.3
Annual State Cost (millions)	$10.4- $24.3
Per Capita Cost	$2,150-$3,100
State Cost per Newly Covered Person	$700 - $1,200
Funding by Source (%)	
Contribution by Insured Individuals	56% - 61%*
Contribution by Employer	6%
Federal Share	0%
State Share	33% - 38%

*Although the employee share is one-third when those signing up are part of an employer-sponsored plan, individuals enrolling on their own would pay two-thirds of the cost. Since the estimates assume large numbers of such individuals opt for this plan, the insured individuals' share averages well above one-third.

APPENDIX F:

ACTUARIAL ANALYSIS OF OPTIONS

Actuarial Model Methodology

The discussion that follows explains the methodology used to develop actuarial estimates of the number of people covered and the cost for each of the options analyzed for the State of Delaware.

Developing the Sample Population

The first step in setting up the model was the development of a sample population of all the individuals residing in the State of Delaware. Delaware has about 552,402 adults and 225,886 kids. We utilized data supplied by the University of Delaware's Center for Applied Demography & Survey Research for this sample population.

The sample population was representative of the socio-economic characteristics of the Delaware population. Each record representing the population contains very detailed information. Our sample file has about 7,742 adult records and 2,725 child records. Each of these adult records represents approximately 71 adults and each child record represents approximately 83 children in the State with almost identical profiles.

Setting Take-up Rates

The next step in setting up the model was to set up our take-up rate tables. Each of our take–up rate tables is a range of numbers between 0 and 1.0 that represent the probability that an individual with certain characteristics will apply for and accept coverage under a specific program option. The take-up rate tables vary by age, sex, income-level, family size and plan type (Medicaid extension, SCHIP extension, employer subsidized plan, subsidized purchasing pool). Initially, we developed these tables based upon Delaware's take-up experience with other state programs, take-up rates for employer provided coverage, take-up experience for the State employee benefit plan and our experience with programs in other states.

Setting Baseline Cost Rates

We also determined a table of baseline cost rates per adult and child for each program. Similar to the baseline take-up rates, the baseline cost rates vary by age, sex, and plan type. We developed the cost rates using the program expenditures for other state-run health programs in Delaware, claims experience from the State of Delaware employee benefit program, cost surveys for employer-provided health benefit programs, information available for the private non-group markets and our knowledge of other state health programs. All costs are based on 2000 experience. They can be adjusted to 2002 with trend rates that reflect the change in costs. We also developed a set of plan design adjustment factors to adjust for the difference between the plan designs underlying the available claims experience and the plan designs outlined in the program options.

Besides considering the specific characteristics of the sample record, the program eligibility provisions are also considered when assigning the baseline take-up rate. For

example, if the program targets individuals with income below 300% of the federal poverty level (FPL), the model will assign a take-up rate of zero to any individual on the sample file with income above 300% of FPL.

Adjusting for Specific Parameters

The next step of the model is a series of parameter adjustments that modify the baseline take-up rates and the cost rates for a specific record. These adjustment factors are for specific parameters that are not recognized in the development of the baseline take-up rates or baseline costs. For example, the take-up rates are adjusted for the level of individual cost sharing required under the program option—higher cost sharing would reduce take-up rates. Other adjustments for the baseline take-up rates include: employment status, insured or uninsured status, outreach/communication programs, and employer size. Adjustments for the baseline costs include: adverse selection/pent-up demand, county where the individual resides, health status, trend and minimum participation requirements.

Consolidating the Model

Finally, all of the pieces described above are consolidated in our model. Our model selects one sample person record, determines the baseline take-up and cost rates for that record, adjusts for the program eligibility provisions and specific parameters and then multiplies the components to produce an expected cost. The formula below summarizes this process:

(Baseline take-up rate varying by age, sex, income level, family size and plan type)
x
(Baseline cost rate per person varying by age, sex, and plan type)
x
(Adjustment factors to baseline take-up and cost rates including eligibility provisions and specific parameters)

= (Expected cost of the program for a sample record)

The model repeats this calculation for each record. Results are saved and accumulated for all of the records. Individuals' contributions to the cost of the program, if any, are also accumulated. The accumulated results from the sample records are then projected to those for the entire population by using the corresponding adult and child population weights. These results are then summarized in exhibits produced by the model.

Some of the participants in the model may be assigned a take-up probability for a program option even though they are already covered by another health plan. We defined these individuals as "crowd-out" participants. The model separately accumulates results

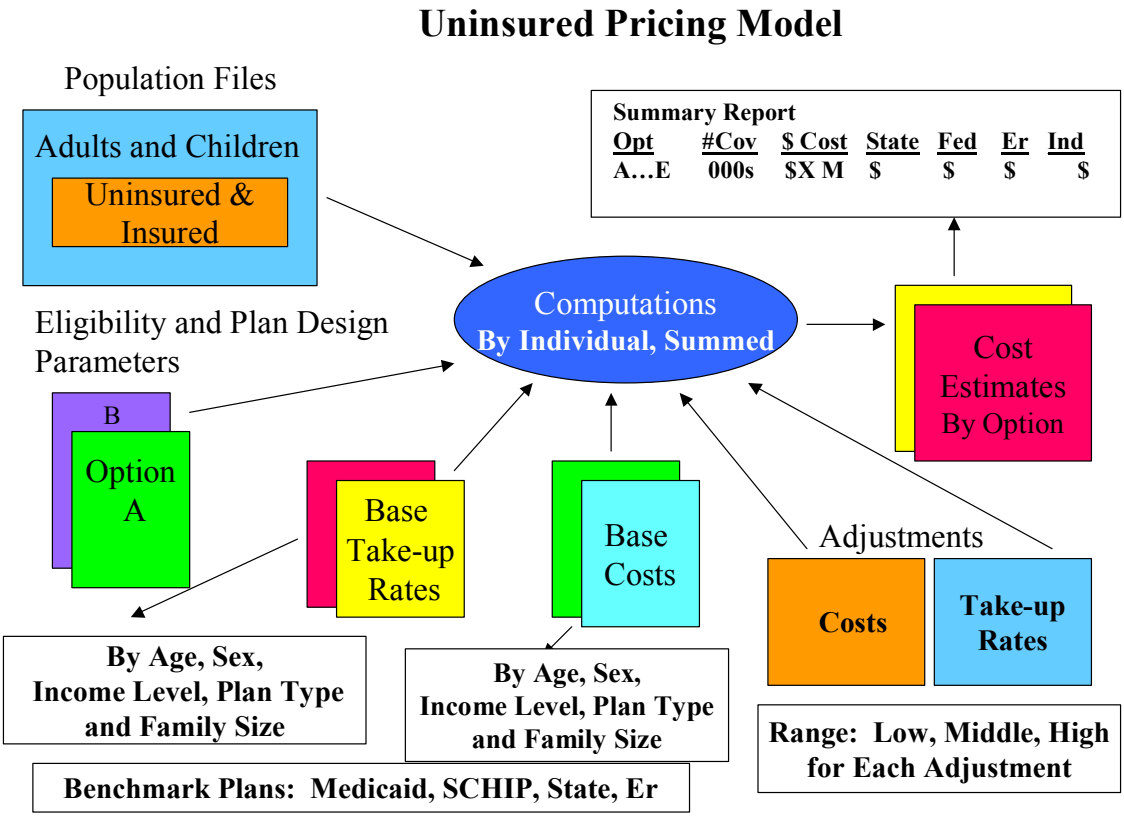
for crowd-out participants, which allows us to properly measure the *net* reduction in the number of uninsured individuals.

Assigning Range Variations

Rather than arriving at a single estimate of the effect of an option in terms of the number of people covered and the cost of the option, we provide an estimate range. The model does this by assigning a range of variation to each specific parameter adjustment we employ in the calculation process. These ranges are based upon our judgments concerning the consistency and credibility of the underlying source data used to develop the baseline take-up rate, baseline costs and parameter adjustment factor. Using the cumulative effects of these ranges, high and low range estimates for each midpoint results are produced in the final exhibits.

This model provides a consistent and reliable methodology for measuring the cost implications of the various program options. It meets the challenge of managing a complicated array of participant characteristics, program eligibility provisions, actuarial benefit plan values and claim cost expectations.

The following graphic displays the model in its current configuration:



APPENDIX G:

POLICY FORUMS

POLICY FORUMS

February 2001

- An explanation of the Commission's Uninsured Action Plan; state planning and service delivery initiatives (CAP).
- Remarks from the Governor and Lt. Governor
- A profile of the state's uninsured population
- A description of the information gathering process to include research, focus group, survey, travel, and future stakeholder session methodologies.
- Presentation by the State Coverage Initiatives Program on state/federal experience.
- Public Dialogue

Approximately three hundred invitations were issued and approximately 80 individuals attended. (Delaware's first major snowstorm of the season unfortunately struck on this day closing schools early throughout the state and impacting our attendance.)

Issues Raised by stakeholders at the event included:

- Part of the planning dialogue should contain discussion of a "single payer system"
- What is underinsurance?
- Pre-existing conditions such as mental health illness should be regarded in planning.
- How will undocumented citizens be regarded in the planning process?
- View the problem from the financial perspective of individuals.
- Recognition that change is incremental and that cultivating public/private partnerships is imperative.
- Create a "suggestion box" web-based tool".
- Any indication of financial support for community screening and disease prevention programs?
- Need to draw conclusions about the adequacy of marketplace competition.

These considerations have been addressed to the extent possible as opportunities have allowed through not only the State Planning activity but also the Community Access Program implementation. Based on feedback obtained at the health policy conference, eligibility for CAP participation includes undocumented citizens who fall within established income guidelines, the issue of underinsurance is being addressed at least for adults between 100 and 200% of the federal poverty level, health status is being collected on all enrollees as a means of introducing applicable disease management protocols.

June 2001

- Report updated numbers from the University of Delaware
- Employer Survey response highlights
- Define guiding principles
- Pros/Cons and preliminary costs of a wide range of options
- Discard options that are clearly not feasible
- Method for gaining input

The June health policy conference was critical for gaining input from key stakeholders. A technological vendor who utilized an "audience response system" of polling was secured and conference participants "voted" on a number of issues throughout the day, including guiding principles, target populations, and options. Voting results indicated concurrence on guiding principles, priority towards addressing the low income population first and other populations incrementally thereafter, and, interestingly, nearly level interest in all options. The single option that scored slightly higher than the others was SCHIP expansion to parents.

September 2001

- Provide research findings
- Discuss the importance of the safety net
- What other states are doing presentation by the Academy
- Recommendations for path forward

The September conference invitation was extended to over 400 individuals and was intended to serve as an unveiling of our findings and recommended path forward. Plans were not to use electronic polling devices but have an extended question and answer period utilizing both microphones and index cards. A panel of state and national experts would respond to questions. An important aspect of the September event was drawing further attention to the critical role played by the safety net, and highlighting the critical role it has played in successfully implementing the Delaware Community Healthcare Access Program.

National events occurring in September precluded our ability to gather a final round of input and continue this collaborative process.

APPENDIX H:

EMPLOYER SURVEY FIELD TESTING

Results from the Employer Survey Field Testing Process

Employers state that health insurance coverage is required for recruitment and retention. Pay 50% of cost of employee's coverage.

Have observed that employees are increasingly aware of and desire benefits – shift towards "family values" amongst new generations.

Waiting periods for coverage, which range ordinarily between immediate to 6 months, are coming more into play as new recruits shop around more liberally within the workforce for employment/benefits packages.

Provision of health insurance cuts into employer bottom lines - as a result continued hire of part-time employees and temporary employees.

Provision of benefits to employees also is requiring an increased contribution from employees and turnover.

Common Concerns:
Cost
Difficulty in locating coverage options and quotes
Nothing to compare quotes against for review

Shared Interests:
Purchasing Pools/Risk Pools
Information/Resources from insurance Commissioner's Office about available health insurance products
Adequate provider panels and quality reports

Emerging Opportunities/Considerations:

Professional Employee Organizations
Employees are "co-owned". Individual organizations retain basic recruitment functions; insurance company takes over the Human Resources function including, Workman's Compensation, payroll, and life and health insurance. There is a per-employee cost but the savings associated with the individual company's loss of need for an HR department allows dollars to be reinvested in health insurance. Magnitude of numbers allows insurance company to offer significantly reduced insurance rates.

Linking health insurance to unemployment insurance.

Women 60 – 65 years of age whose husbands have carried benefits but are now Medicare eligible at 65, or who are divorcing. (Particularly striking in Sussex with retirement population).

APPENDIX I:

SOUNDING BOARD MEETINGS

Key Discussion Points from Sounding Board Meetings:

- Unilateral agreement that lack of access to insurance coverage is a barrier for many individuals to access health services. There was concurrence from this group that plans be incremental and targeted.

- Strong interest in gaining a better understanding of the State's fiscal and philosophical priorities.

- Interest in how total dollars spent on uninsured in Delaware compare to that expended in other states.

- Discussion about measuring and evaluating success and general agreement to the guiding principles discussed in Chapter 4 of this report.

- Acknowledgement of the problem of Cost-Shift.

- Need to continue exploring methods of maximizing State return on the federal dollar.

- Additional focus group ideas were suggested in the event that focus groups are completed again; e.g. target employees who work for firms that do offer coverage but employee cannot participate.

APPENDIX J:

SCI REQUIRED TABLES

State	Uninsured %			
	CPS** Estimate 1998-2000 3-year average	State Estimate	Year of State Estimate	State Measure of Coverage Status*
Arkansas	19.3%			
Delaware	13.1%	9.7%	2000	DE Behavioral Risk Surveillance System- 2700 phone interviews (UDEL for CDC and DE Public Health) DE Consumer Assessment of Health Plans Survey, 1800 telephone interviews (UDEL for DE Health Care Commission)
Illinois	13.8%			
Iowa	9.9%			
Kansas	11.4%			
Massachusetts	11.1%			
Minnesota	8.8%			
New Hampshire	11.1%			
Oregon	14.1%			
Vermont	10.6%			
Wisconsin	10.3%			
Example	12.0%	9.9%	2000	Covered at time of survey, <65

*Basis of estimate: status of current coverage, status based on any insurance during the year, and age groups (if restricted)

** CPS estimate is based on whether the individual had coverage anytime during the year.

Table of State Strategies to Obtain Information						
State	Household/Individual			Employer		
	Survey	Focus Groups	Other	Survey	Focus Groups	Other
Arkansas						
Delaware		YES		YES	YES	
Illinois						
Iowa						
Kansas						
Massachusetts						
Minnesota						
New Hampshire						
Oregon						
Vermont						
Wisconsin						
Example	Yes	No	Key Informant Interviews	No	Yes	N/A

Table of Household Surveys

State	Survey Title	Year	Previous Years	Methodology	Sample Size and Sample Design	Reported Response Rate	Survey Length	Vendors	Agency Who Oversees Survey	Funding Source and Budget
Arkansas										
Delaware										
Illinois										
Iowa										
Kansas										
Massachusetts										
Minnesota										
New Hampshire										
Oregon										
Vermont										
Wisconsin										
Example	Example State Health Interview Survey	2001	1997, 1992	a) Telephone b) In-person interviews in select areas	a) RDD 10,000 stratified by geography b) Non probability, purposive sample	a) 60% b) 70%	a) 20 mins. b) 30 mins.	a) Health Research Consulting, Inc. b) Community Outreach Partners, Inc.	State Department of Health and Insurance	HRSA State Planning Grant; $450,000

Table of Focus Groups (non-employer)								
State	Number of Groups	Number of Participants in Each Group	Target Populations	Purpose of Focus Groups	Recruitment Process	Vendors	Agency Who Oversees Survey	Funding Source and Budget
Arkansas								
Delaware	Two	4-6 people	Uninsured individuals employed by firms with less than 50 employees	Better understanding of hardship, expectations of employer, and reactions to possible strategies	Chambers of Commerce provided business contacts. Employers in turn solicited employees. Federally qualified health centers solicited patients. Offered $50-incentive.	Health Management Associates		HRSA- focus groups factored as expense within an overall $395,000.00 health policy consulting agreement.
Illinois								
Iowa								
Kansas								
Massachusetts								
Minnesota								
New Hampshire								
Oregon								
Vermont								
Wisconsin								

Table of Employer Surveys												
State	Survey Title	Year	Previous Years	Sample Size	Sample Design	Methodology	Reported Response Rate	Survey Length	Types of Employers Surveyed	Vendors	Agency Who Oversees	Funding Source and Budget
Arkansas												
Delaware	Employer Survey	2001	N/a	1600	Stratified by # of employees	Mail survey	44.7%	15 minutes	<50 employees	University Research Center	DE Health Care Commission	HRSA-SPG $30,000
Illinois												
Iowa												
Kansas												
Massachusetts												
Minnesota												
New Hampshire												
Oregon												
Vermont												
Wisconsin												
Example	Example Employer Survey	2001	N/A	1,500	Stratified sample by size; Over-sample large employers (>100 employees)	Mail survey.	40%	30 minutes	All non-government employers with at least one employee.	State University Survey Research Center	Dept. of Commerce and Insurance.	HRSA State Planning Grant; $250,000

Table of Employer Focus Groups								
State	Number of Groups	Number of Participants in Each Group	Types of Employers Participating	Purpose of Focus Groups	Recruitment Process	Vendors	Agency Who Oversees	Funding Source and Budget
Arkansas								
Delaware	Two	4-6 people	Firms with less than 50 employees who do not offer coverage, or did not within the past two years.	Understanding of hardships, understanding of what would motivate offering coverage, and reaction to strategies.	State and local Chambers provided members who fit eligibility criteria based on firm size. Vendor completed recruitment calls.	Health Management Associates		HRSA-focus groups factored as expense within an overall $395,000.00 health policy consulting agreement.
Illinois								
Iowa								
Kansas								
Massachusetts								
Minnesota								
New Hampshire								
Oregon								
Vermont								
Wisconsin								